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The Application of Labor and Antitrust Laws to Physician Unions: The Need for A Re-Evaluation of Traditional Concepts In a Radically Changing Field

By CHARLES B. CRAVER*

> The character of [medical] practice is changing under many pressures. The higher costs of medical care have given great incentive to prepayment. The increase in medical knowledge and new techniques have created specialties and heightened interdependence among doctors, and . . . more and more specialists and general practitioners have joined in group practice arrangements. The need for expensive equipment makes individual entrepreneurship difficult so that hospitals, groups of doctors, and consumer organizations able to supply the needed capital have hired doctors, sometimes on a salaried basis. The traditional practice where a doctor works alone and charges a fee for each service rendered is being challenged by all these developments . . . .
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> By encouraging and promoting such changes, labor comes into conflict with the officials of organized medicine . . . .[1]

Introduction

The relationship which traditionally existed between a private physician and the hospital where he practiced his profession was generally attenuated. The hospital merely provided the facilities which enabled the practitioner to treat his patients;[2] the physician was solely responsible for the medical service he provided. "A hospital had neither

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1. R. MUNTS, BARGAINING FOR HEALTH 144 (1967). For a discussion of the strong opposition historically advanced by the American Medical Association to modifications in traditional forms of practice, *see* Comment, *The American Medical Associations: Power, Purpose and Politics in Organized Medicine*, 63 YALE L.J. 938 (1954).

2. Comment, *The Hospital and the Staff Physician—An Expanding Duty of Care*, 7 CREIGHTON L. REV. 249 (1974) [hereinafter cited as *Staff Physician*].

the right nor the ability to practice medicine and was, therefore, incapable of supervising the physician who utilized its facilities but operated as an independent contractor."[3] In recent years, however, the once sacrosanct independent doctor-hospital relationship has changed markedly.

> Such an institution is no longer a mere building where private practitioners of medicine care for their private patients. Rather, the community hospital as a corporate institution is being called upon to assume the role of a comprehensive health center ultimately responsible for arranging and co-ordinating total health care.[4]

Lately, the once wholly independent medical practitioner has suffered a substantial diminution in his individual authority. He has found it necessary to deal with the well organized and powerful health insurance industry which today pays for over two-thirds of the nation's medical expenses.[5] The physician has become increasingly dependent upon the hospital, as membership on the staff of a health care institution has come to be a prerequisite to a full and successful practice for most physicians.[6] A pervasive increase in the extent of control which health care institutions exert over their professional staff members has, however, accompanied such staff privileges. Although some of the impetus for the proliferation of hospital controls has been self-generated,[7] external developments have more significantly affected and altered the physician-health care institution relationship.

Medicare[8] and Medicaid[9] programs, fostered by federal legislation,

3. *Id.*; *see* Moon v. Mercy Hosp., 150 Colo. 430, 373 P.2d 944 (1962); Purcell v. Poor Sisters of St. Francis Seraph, 147 Colo. 478, 364 P.2d 184 (1961).

4. Southwick, *The Hospital As an Institution—Expanding Responsibilities Change Its Relationship With the Staff Physician*, 9 CAL. WEST. L. REV. 429 (1973) [hereinafter cited as Southwick]. "The hospital, once nothing more than a hotel for the sick, has become an integral part of the healing process." *Staff Physician, supra* note 2, at 249; *see* Fabro, *Legal Relationship of Physician to Hospital*, 43 CONN. B.J. 418 (1969); Mueller, *The Expanding Duty of the Hospital to the Patient*, 47 NEB. L. REV. 337 (1968).

5. Wall Street Journal, July 5, 1972, at 7, col. 1.

6. Southwick, *supra* note 4, at 453.

7. *See, e.g.*, AMERICAN HOSPITAL ASSOCIATION, PATIENT'S BILL OF RIGHTS 1 (1972). The preamble recognizes the medical responsibility which a hospital owes to its patient. Such a novel approach necessitates the imposition of quality control mechanisms by hospitals over the medical care provided by staff physicians if they are to fulfill their overall obligation to the patients. *See* Southwick, *supra* note 4, at 434.

8. Medicare was established by the 1965 amendments to the Social Security Act for the purpose of providing health insurance for the aged. 42 U.S.C. §§ 1395-95*ll* (1970), *as amended*, (Supp. III, 1973). Part A of the program covers hospital costs (42 U.S.C. §§ 1395 c to i - 2 (1970 & Supp. III, 1973)), while part B generally pertains to the costs of physician services and certain ancillary expenses (42 U.S.C. §§ 1395j-w 1970 & Supp. III, 1973)). *See generally* Wolkstein, *Medicare 1971: Changing Attitudes and Changing Legislation*, 35 L. & CONTEMP. PROB. 697 (1970).

9. Medicaid concerns the Grants to States for Medical Assistance Program which

have begun to have a considerable impact upon the independence of doctors practicing at hospitals. Each hospital which provides health care services to Medicare patients must have a utilization review committee which is required to supervise and review the necessity and propriety of medical services furnished to those patients.[10] This requirement forces hospitals to exercise a far greater degree of control over their staff physicians than has previously been exerted. Additional Medicare and Medicaid requirements will further erode the traditional professional independence of medical practitioners.

The Social Security Amendments of 1972[11] require the establishment of Professional Standards Review Organizations (PSROs) which will be responsible for carefully monitoring the medical care provided to Medicare and Medicaid beneficiaries.[12] PSROs will ultimately be required to oversee the quality and nature of medical care which physicians and hospitals accord to their many Medicare and Medicaid patients.[13] The same 1972 enactment also provides strong impetus for the creation of large group medical practices which will further diminish the ability of private practitioners to maintain their historical individuality and independence.

During the past few years there has been a significant decline in the number of practitioners who have continued the tradition of individual-

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was enacted "[f]or the purpose of enabling each State . . . to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals . . . and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence of self-care . . . ." 42 U.S.C. § 1396 (Supp. III, 1973). Such programs must be established by individual states, and must satisfy federal requirements to be eligible to receive matching funds. 42 U.S.C. §§ 1396a-b (1970). *See generally* Stevens & Stevens, *Medicaid: Anatomy of a Dilemma*, 35 L. & CONTEMP. PROB. 348 (1970).

10. 42 U.S.C. §§ 1395x(e)(6), x(k) (1970 & Supp. III, 1973). Many private insurance contract arrangements and some state hospital licensure statutes similarly require such hospital utilization review committees. *See* Southwick, *supra* note 4, at 429.

11. §§ 101-413, 86 Stat. 1329.

12. *Id.* § 249F, 42 U.S.C. § 1320c-4 (Supp. III, 1973). *See* Southwick, *supra* note 4, at 429. Local PSROs may elect to have hospital utilization review committees act as the initial reviewing bodies. 42 U.S.C. § 1320c-4(e) (Supp. III, 1973).

13. *See generally*, Flasnor, Reed, Coburn, & Fine, *Professional Standards Review Organizations: Analysis of Their Development and Implementation Based on a Preliminary Review of the Hospital Admission and Surveillance Program in Illinois*, 223 J.A.M.A. 1473 (1973); Note, *Federally Imposed Self-Regulation of Medical Practice: A Critique of the Professional Standards Review Organization*, 42 GEO. WASH. L. REV. 822 (1974).

The AMA has strongly opposed the PSRO legislation because of the fact that it will require doctors to conform to pre-established professional norms, rather than to traditional individual judgment. *See, e.g.*, A.M.A. News, July 2/9, 1973, at 6, col. 1.

ized practice, and a commensurate proliferation of well organized group practices.[14] The phenomenal success of many of these group programs has frequently been associated with their innovative willingness to provide guaranteed medical care on a set fee, prepayment basis to subscribing patients.[15] The rapid expansion of such group practice prepayment plans is certain to continue, since one of the sections of the Social Security Amendments of 1972[16] authorizes the Secretary of Health, Education and Welfare to enter into contractual arrangements with qualified group health programs (health maintenance organizations) under which they will be reimbursed for providing health care to Medicare recipients on a per capita prepayment basis.[17] Furthermore, the Health Maintenance Organization Act of 1973[18] requires all employers who are subject to the federal minimum wage law[19] and who employ at least twenty-five employees per calendar quarter to include in any health benefit plan which they provide an option which will permit employees to choose to be included in a qualified health maintenance organization if one exists in the geographical area.[20] These health care

14. Comment, *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis*, 84 HARV. L. REV. 887, 903 (1971) [hereinafter cited as *Prepaid Group Practice*]. *See also* Hansen, *Laws Affecting Group Health Plans*, 35 IOWA L. REV. 209 (1950).

15. The most successful integrated prepayment health care program has been the Kaiser Foundation Health Plan which currently has over 2,000,000 members. *Prepaid Group Practice, supra* note 14, at 911; see Gerstel & Du Bois, *The Medical Care Program of the Kaiser Foundation Health Plan*, in HEALTH INSURANCE PLANS: STUDIES IN ORGANIATIONAL DIVERSITY 292 (1970). For a history of the Kaiser Foundation Health Plan during its formative years, *see* KAISER FOUNDATION MEDICAL CARE PROGRAM ANN. REP. 2-10 (1960). The prepayment Group Health Association plan of Washington, D.C., with over 73,000 subscribers, is also well known. *See Prepaid Group Practice, supra* note 14, at 913 & n.67. *See also* Phelan, Erickson, & Fleming, *Group Practice Prepayment: An Approach to Delivering Organized Health Services*, 35 L. & CONTEMP. PROB. 796 (1970).

16. Social Security Amendment of 1972, § 226, 42 U.S.C. § 1395mm (Supp. III, 1973). The HMO legislation was part of the pervasive Social Security Amendments of 1972. §§ 101-413, 86 Stat. 1329; *see* Note, *Federally Imposed Self-Regulation of Medical Practice: A Critique of the Professional Standards Review Organization*, 42 GEO. WASH. L. REV. 822, 823-24 n.5 (1974).

17. 42 U.S.C. § 1395mm (Supp. III, 1973); *see* Stern, *Health Care Expansion: Provisions of the Health Maintenance Organization Act of 1973*, 8 CLEARINGHOUSE REV. 89 (1974). *See also* Holley & Carlson, *The Legal Context for the Development of Health Maintenance Organizations*, 24 STAN. L. REV. 644 (1972).

18. Act of Dec. 29, 1973, Pub. L. No. 93-222, §§ 1-7, 87 Stat. 914.

19. Fair Labor Standards Act of 1938, 29 U.S.C. §§ 201-19 (1970), *as amended* (Supp. III, 1973).

20. 42 U.S.C.A. § 300e-9 (1974); *see* Stern, *Health Care Expansion: Provisions of the Health Maintenance Organization Act of 1973*, 8 CLEARINGHOUSE REV. 89-90 (1974). The 1973 enactment also allows the Secretary of Health Education and Welfare to provide financial assistance to incipient health maintenance organizations.

organizations will necessarily exercise a vital degree of control over the physicians who provide the requisite medical services, as they will involve extensive scrutiny by others of the propriety and nature of medical determinations.

In the future, physicians will be forced increasingly to deal with large insurance carriers, hospital review boards, PSROs, and other institutional organizations. Against such powerful groups, the individual doctor is relatively helpless; he will be forced to accept the conditions of the relationship unilaterally established by them[21] or he will have to forego meaningful opportunities for lucrative employment. Recognizing the weakness inherent in their individual positions, doctors have begun to appreciate the need to establish their own organizational strength.[22] Private physicians are now attempting to combat the strength of the institutional Goliaths by forming and joining associations, guilds, and even unions.[23] Such organizational efforts, however, face significant legal problems.

If traditional legal concepts pertaining to the status of physicians are unthinkingly and anachronistically applied to the united endeavors of all doctors, not only may the physicians be forced to forego the labor relations rights and protections generally available to regular workers,[24] but also they may be exposed to the risk of substantial antitrust liability.[25] However, in recognition of the radical evolutionary process pertaining to modern medical relationships, "courts and legislatures throughout the country have come to realize that traditional legal analyses of these [doctor-hospital] relationships accord neither con-

21. When a physician elects to participate in an institutionalized program, his independence must often be sacrificed to the efficient functioning of the organization. *See Prepaid Group Practice, supra* note 14, at 947.

22. Although the American Medical Association (AMA) purports to represent the interests of all physicians, many of the activist, organization-minded physicians believe that it has thus far done relatively little to provide doctors with meaningful assistance concerning their dealings with health care institutions. Furthermore, they are quite skeptical regarding the possibility that the AMA will significantly alter its posture in the future.

23. *See, e.g.*, Am. Med. News, April 10, 1972, at 3; Am. Med. News, April 3, 1972, at 1; L.A. Times, Jan. 29, 1973, § 1, at 4, col. 6; Medical Economics, Jan. 3, 1972, at 103; Medical Economics, July 17, 1972, at 57-61.

24. See text accompanying notes 29-92 *infra*.

25. See text accompanying notes 93-194 *infra*. *See generally* Comment, *Private Physician Unions: Federal Antitrust and Labor Law Implications*, 20 U.C.L.A.L. REV. 983 (1973) [hereinafter cited as *Physician Unions*]. Although this comment explicated the traditional legal concepts indigenous to organized action by physicians, it did not meaningfully explore the possible ramifications incident to the evolutionary nature of the modern status of doctors.

temporary realities nor societal needs."[26] They have consequently demonstrated a refreshing inclination to reconsider and modify significantly many of the traditional legal doctrines relevant to the doctor-hospital relationship. Although the enlightened developments in this area have thus far been confined generally to the question of hospital responsibility for the improper acts of staff physicians,[27] there is no reason why such innovative evaluative techniques should not be similarly used to reassess other traditional attitudes concerning physicians and health care institutions.

This article will explore traditional labor and antitrust concepts as they apply to organized action by physicians[28] and will suggest an approach which would provide meaningful protection for modern-day practitioners who require united strength, while simultaneously limiting unconscionable interference with the rights of the general public.

Labor Law Considerations

NLRA Coverage

Since the enactment of the Wagner Act[29] in 1935, workers employed by private employers have generally enjoyed significant labor law protection. Nevertheless, until very recently, physicians employed by private, nonprofit hospitals were not accorded the rights available to other workers because the NLRA expressly excluded such health care institutions from its coverage.[30] On July 26, 1974, however, the presi-

26. Note, *Independent Duty of a Hospital to Prevent Physicians' Malpractice*, 15 ARIZ. L. REV. 953 (1973) [hereinafter cited as *Malpractice*].

27. *See generally* Hanson & Stromberg, *Hospital Liability for Negligence*, 21 HASTINGS L.J. 1 (1969) [hereinafter cited as Hanson & Stromberg]; Mueller, *The Expanding Duty of the Hospital to the Patient*, 47 NEB. L. REV. 337 (1968); Southwick, *supra* note 4; Southwick, *The Hospital's New Responsibility*, 17 CLEV.-MAR. L. REV. 146 (1968); Southwick, *The Law of Hospital Liability*, in LEGAL MEDICINE ANNUAL 91 (1970); *Malpractice, supra* note 5; *Staff Physician, supra* note 2; Note, *Hospital Liability for the Negligence of Physicians: Some Needed Legal Sutures*, 26 U. FLA. L. REV. 844 (1974); Comment, *Liability of a Hospital for Negligent Acts of a Physician-Employee*, 18 OKLA. L. REV. 77 (1965).

28. In addition to a consideration of federal labor and antitrust law, this article will discuss relevant California legal principles. Discussion is limited to California law because California coverage of these areas is fairly representative of state laws dealing with these subjects, there has been substantial physician organizing in California, and while in practice the author acted as counsel to a California-based physicians' union.

29. National Labor Relations Act, ch. 372, 49 Stat. 449 (1935) (codified at 29 U.S.C.A. §§ 151-68 (1973 & Supp. 1975)).

30. NLRA section 2(2), 29 U.S.C. section 152(2) (1970), which defined those employers subject to the jurisdiction of the NLRA, expressly excluded "any corporation or association operating a hospital, if no part of the net earnings inures to the benefit of

dent signed Public Law 93-360,[31] which has the effect of extending the coverage of the NLRA to all persons *employed* by private, nonprofit hospitals.[32] This occurrence may result in great benefits to doctors who desire to organize.

Workers within the coverage of the NLRA are afforded fundamental benefits and protections. They "have the right to self-organization, to form, join or assist labor organizations, to bargain collectively through representatives of their own choosing, and to engage in other concerted activities for the purpose of collective bargaining or other mutual aid or protection . . . ."[33] Their employers may not interfere with their exercise of these protected rights,[34] nor may their employers discriminate against them as a result of their having exercised such rights.[35] Furthermore, when a majority of the workers employed in an appropriate bargaining unit designate or select a particular labor or-

any private shareholder or individual . . . ." But see notes 31-32 & accompanying text *infra.*

It should also be noted that the NLRA has traditionally excluded from its coverage all branches of the United States Government, as well as all states and political subdivisions thereof. 29 U.S.C. § 152(2) (1970). See note 80 *infra.*

31. Act of July 26, 1974, Pub. L. 93-360, 88 Stat. 395, *amending* 29 U.S.C.A. §§ 151-68 (1973 & Supp. 1975).

32. The effective date of the amending legislation was August 25, 1974. The enactment not only removed the private, nonprofit hospital exemption from section 2(2) of the NLRA, but also added some further provisions dealing with such medical facilities. *See generally Guidelines Issued by the General Counsel of the National Labor Relations Board for use of Board Regional Offices in Unfair Labor Practices Cases Arising Under the 1974 Nonprofit Hospital Amendments to the Taft-Hartley Act,* 86 LAB. REL. REP. 371 (1974).

Prior to the 1974 amendments, doctors employed by private, proprietary hospitals with gross annual revenues of at least $250,000, Butte Medical Hosp. Properties, 168 N.L.R.B. 266 (1967), private, proprietary nursing homes with gross annual revenues of at least $100,000, University Nursing Home, Inc., 168 N.L.R.B. 263 (1967), or private, nonprofit extended care nursing facilities with gross yearly income of at least $100,000, Drexel Home, Inc., 182 N.L.R.B. 1045 (1970), were under the jurisdiction of the NLRA. The jurisdictional standard applicable with respect to private, proprietary hospitals has been extended to private, nonprofit hospitals. East Oakland Community Health Alliance, Inc., 218 N.L.R.B. No. 193, 89 L.R.R.M. 1372 (1975).

33. NLRA § 7, 29 U.S.C. § 157 (1970). That section also provides workers with the concomitant "right to refrain from any or all of such activities." *Id. See generally* C. MORRIS, THE DEVELOPING LABOR LAW (1971).

34. NLRA section 8(a)(1), 29 U.S.C. section 158(a)(1) (1970): "It shall be an unfair labor practice for an employer - (1) to interfere with, restrain, or coerce employees in the exercise of the rights guaranteed in section 7."

35. NLRA section 8(a)(3), 29 U.S.C. section 158(a)(3) (1970): "It shall be an unfair labor practice for an employer . . . (3) by discrimination in regard to hire or tenure of employment or any term or condition of employment to encourage or discourage membership in any labor organization . . . ."

ganization[36] as their exclusive representative,[37] their employer is obligated to negotiate in good faith with that organization concerning wages, hours, and other terms and conditions of employment.[38] In order to avail themselves of the rights and protections provided by the NLRA, however, physicians must be considered to be employees within the meaning of that Act.[39]

Since the original Wagner Act[40] did not specifically define the term "employee," the National Labor Relations Board (NLRB or labor board) was granted broad administrative discretion in its determination of the appropriate scope of NLRA coverage. The United States Supreme Court recognized in *NLRB v. Hearst Publications Inc.*,[41] that traditional common law distinctions between employees and independent contractors were not mandatory:

> The mischief at which the Act is aimed and the remedies it offers are not confined exclusively to "employees" within the traditional legal distinctions separating them from "independent contractors." . . .
>
> Unless the common-law tests are to be imported and made exclusively controlling, without regard to the statute's purposes, it cannot be irrelevant that the particular workers [in question] are subject, as a matter of economic fact, to the evils the statute was designed to eradicate and that the remedies it affords are appropriate for preventing them or curing their harmful effects in the special situation. Interruptions of commerce through strikes and unrest may stem as well from labor disputes between some who,

36. NLRA section 2(5), 29 U.S.C. section 152(5) (1970), broadly defines "labor organization" to include: "any organization of any kind, or any agency or employee representation committee or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning grievances, labor disputes, wages, rates of pay, hours of employment, or conditions of work." Any guild, association, or union of physicians, therefore, would clearly be a "labor organization" within the meaning of the NLRA. See text accompanying note 23 *supra*.

37. *See* NLRA § 9(a), 29 U.S.C. § 159(a) (1970).

38. Section 8(a)(5) of the NLRA makes it an unfair labor practice for an employer within the jurisdiction of the NLRA to fail to bargain collectively with the duly designated representative of his employees. 29 U.S.C. § 158(a)(5) (1970). See section 8(d) regarding the scope of the employer's negotiating obligation. 29 U.S.C. § 158(d) (1970). *See generally* Duvin, *The Duty to Bargain: Law in Search of Policy*, 64 COLUM. L. REV. 248 (1964); Feinsinger, *The National Labor Relations Act and Collective Bargaining*, 57 MICH. L. REV. 807 (1959); Fleming, *New Challenges for Collective Bargaining*, 1964 WIS. L. REV. 426. *See also* Note, *Collective Bargaining and the Professional Employee*, 69 COLUM. L. REV. 277 (1969).

39. Section 7 is expressly applicable only to "employees." 29 U.S.C. § 157 (1970). Similarly, sections 8(a)(1), 8(a)(3), and 8(a)(5) only afford general protection to "employees." See 29 U.S.C. §§ 158(a)(5), (d) (1970). See notes 34-35 *supra*.

40. Ch. 372, 49 Stat. 449 (1935).

41. 322 U.S. 111 (1944).

> for other purposes, are technically "independent contractors" and their employers as from disputes between persons who, for those purposes, are "employees" and their employers. Inequality of bargaining power in controversies over wages, hours, and working conditions may as well characterize the status of the one group as of the other. The former, when acting alone, may be as "helpless in dealing with an employer," as "dependent . . . on his daily wage" and as "unable to leave the employ and to resist arbitrary and unfair treatment" as the latter. For each, "union . . . [may be] essential to give . . . opportunity to deal on equality with their employer." And for each, collective bargaining may be appropriate and effective for the "friendly adjustment of industrial disputes arising out of differences as to wages, hours, or other working conditions." In short, when the particular situation of employment combines these characteristics, so that the economic facts of the relation make it more nearly one of employment than of independent business enterprise with respect to the ends sought to be accomplished by the legislation, those characteristics may outweigh technical legal classification for purposes unrelated to the statute's objectives and bring the relation within its protections.[42]

In 1947, the Eightieth Congress expressly rejected the policy oriented analysis which had been adopted by the labor board and the Supreme Court in *Hearst Publications*. The Taft-Hartley Act[43] amendments to the NLRA modified the statutory definition of the term employee expressly to *exclude* "any individual having the status of an independent contractor."[44] By this statutory alteration, Congress clearly indicated its intention that only the ordinary meaning of the term employee comes within the coverage of the NLRA. The relevant legislative history pertaining to the 1947 enactment unequivocally demonstrates that this change constituted a complete disavowal of the *Hearst Publications* emphasis on economic and policy considerations.[45] The Supreme Court has since recognized that when questions arise concern-

42. NLRB v. Hearst Publications, Inc., 322 U.S. 111, 126-28 (1944) (citations omitted). In *Hearst Publications*, the Supreme Court accepted the Labor Board's extension of NLRA's protection to independent newspaper sellers concerning their relationship with the newspaper from which they obtained their papers.

43. Labor Management Relations Act, ch. 120, 61 Stat. 136 (codified at 29 U.S.C. §§ 141-87 (1970)).

44. *Id.* § 101, at 137-38; see section 2(3) of the NLRA which provides, in pertinent part: "The term 'employee' shall include any employee . . . but shall not include . . . any individual having the status of an independent contractor . . . ." 29 U.S.C. § 152(3) (1970).

45. *See* H.R. Rep. No. 245, 80th Cong., 1st Sess. 18 (1947), in 1 LEGISLATIVE HISTORY OF THE LABOR MANAGEMENT RELATIONS ACT, 1947 309 (1948) [hereinafter cited as LEGISLATIVE HISTORY]; H.R. Conf. Rep. No. 510, 80th Cong., 1st Sess. 32-33 (1947), in 1 LEGISLATIVE HISTORY at 536-37; 2 LEGISLATIVE HISTORY at 1537 (comments of Senator Taft). *See also* Boire v. Greyhound Corp., 376 U.S. 473, 481 & n.10 (1964); NLRB v. United Ins. Co., 390 U.S. 254, 256 (1968).

ing the scope of the term employee, common law agency principles should be used to make the requisite determination.[46]

In *Brown v. NLRB*,[47] the Ninth Circuit cited with approval the factors delineated in section 220(2) of the *Restatement Second of Agency* as the elements which are to be applied when ascertaining, for NLRA purposes, whether one performing work for another is a protected employee or an unprotected independent contractor. These factors are: (1) the extent of control which, by the agreement, the master may exercise over the details of the work; (2) whether the one employed is engaged in a distinct occupation or business; (3) the kind of occupation and whether, in the locality, the work is usually done under the direction of the employer; (4) the skill required in the particular operation; (5) whether the employer supplies the instrumentalities, tools, and the place of work; (6) the length of time for which the person is employed; (7) whether payment is by the time or by the job; (8) whether the work is a part of the regular business of the employer; (9) whether the parties believe they are creating the relation of master and servant; and (10) whether the principal is in business.[48] It appears that, at least in the Ninth Circuit, these factors will ultimately have to be applied when a group of physicians associated with a particular health care institution requests NLRA protection.[49] Absent a finding that the physicians are employees, they will receive none of the benefits of the NLRA.

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46. *See* NLRB v. United Ins. Co., 390 U.S. 254 (1968).

47. 462 F.2d 699, 705 (9th Cir. 1972); *see* Carnation Co. v. NLRB, 429 F.2d 1130, 1133-34 (9th Cir. 1970); Associated Independent Owner-Operators, Inc. v. NLRB, 407 F.2d 1383, 1385 (9th Cir. 1969).

48. 462 F.2d at 705 n.10.

49. It should be noted that even a cursory examination of factors listed in the *Restatement Second of Agency* should be sufficient to dispel any possible notion that an employment relationship exists between a physician and a particular patient. That attenuated relationship, which is fundamentally controlled almost completely by the professional practitioner, has traditionally been considered to be one of independent contractor, rather than one of employment. Absent some drastic change in the future, this legal classification will continue to be recognized.

Although one could undoubtedly argue that the relationship which a modern physician has with an insurance carrier, whether privately run or governmentally operated (*e.g.*, Medicare), should be considered to be one of employment, rather than one of independent contractor, it is most unlikely that a labor relations agency or court would accept this contention. While it is certainly true that such entities provide a substantial portion of the average doctor's income (see note 7 & accompanying text *supra*), they do not enter into direct relationships with the physicians: they merely afford financial protection for their insured patients. In addition, the element of control which an insurance carrier may exercise over a doctor's work is usually exercised indirectly through a hospital utilization review committee (see note 10 & accompanying text *supra*) or an independent PSRO (see notes 12-13 & accompanying text *supra*) and

Staff Physician-Hospital Relationship

The medical staff of a hospital is generally divided into several distinct categories. Resident and intern physicians are usually salaried personnel subject to sufficient hospital control to render them employees of the institution.[50] At the opposite extreme are courtesy staff members, who are in no way involved in the operation of the facility but who are merely allowed occasionally to admit their patients to the hospital so that they may treat them there.[51] Courtesy staff members are classic independent entrepreneurs who are excluded from NLRA coverage by the independent contractor exemption contained in section 2(3).[52] Situated somewhere between the employee interns and residents and the nonemployee courtesy staff doctors are the active staff members. This group consists of the physicians who not only practice at the hospital on a regular basis, but also participate actively in the organization and government of the institutional medical staff.[53] It is this group which will in the future present the most difficulty when the appropriate legal body[54] endeavors to ascertain whether they are entitled to the benefits and protections afforded by the NLRA.

Since the enactment of the 1974 amendment which extended NLRA coverage to private, nonprofit hospitals,[55] the labor board has

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such review is generally of a post hoc nature. A carrier does not meaningfully regulate the professional conduct of the physician *during* the actual performance of his work, as an employer would usually do vis-à-vis one of his employees. On the contrary, the carrier tends to evaluate only what the doctor has already done, and for the sole purpose of determining what amount of reimbursement is appropriate under the health care policy which it has with an insured patient. Thus, while an insurance carrier may certainly have a direct impact upon the remuneration received by the physician, it has no real control over his working conditions, nor generally does it control in advance the work undertaken by the doctor. Any relationship which might exist between a carrier and a practitioner is clearly one of independent contractor, not one of employment.

50. *See Malpractice, supra* note 26, at 954 n.3; 2A HOSPITAL LAW MANUAL, *Negligence* § 1, 8-11 (1962). Although these sources pertain directly to the applicability of the *respondeat superior* doctrine to hospital liability for the negligent acts of residents and interns, their finding of a master-servant relationship is premised upon regular common law agency principles. A similar employment relationship would be present with respect to other salaried physicians directly employed on a full or part-time basis by a hospital.

51. *See* Note, *Hospital Staff Privileges: The Need for Legislation*, 17 STAN. L. REV. 900, 904 (1965) [hereinafter cited as *Staff Privileges*]; *Malpractice, supra* note 26, at 954 n.3.

52. *See* note 42 & accompanying text *supra.*

53. *See Staff Privileges, supra* note 51, at 904.

54. Although this determination will initially have to be made by the NLRB, the decision will be of sufficient magnitude to warrant a prediction that appellate review will be invoked before the question is finally resolved.

55. See notes 31-32 & accompanying text *supra.*

not, unfortunately, been required to define the legal status of active staff doctors. One reason for this situation is that NLRB General Counsel Peter Nash recently decided unilaterally to preclude labor board consideration of this vital question by refusing to issue an unfair labor practice complaint[56] in a case in which it was alleged that a hospital had refused to bargain in good faith[57] concerning the duties of staff physicians who served on the hospital's utilization review committee.[58] Although General Counsel Nash recognized that staff physicians were required to serve on such hospital committees as a *quid pro quo* for their right to practice at the facility, and that the functioning of such committees was essential to the proper operation of the institution, he decided that the hospital did not exercise sufficient control over the *committee work* of the doctors to warrant the finding of an employment relationship regarding such *committee work*.[59] No findings were made with respect to the *overall* physician-hospital relationship, as the issue was not raised. It is this broader relationship which will be the focus of future NLRB cases. When such questions arise the general counsel, the labor board, and the courts will, hopefully, move "away from the mechanical application of doctrinal rules toward a more realistic appraisal of the relationship between legal theory and social reality."[60]

Application of the ten factors delineated in the *Restatement Second of Agency* to the staff physican-hospital situation for the purpose of distinguishing between employment and independent contractor relationships[61] indicates that the ultimate determination will necessarily be

56. When the general counsel declines to issue an unfair labor practice complaint after a charge has been filed, not only is the labor board denied the opportunity to consider the matter (see NLRA § 3(d), 29 U.S.C. § 153(d) (1970)), but owing to the unreviewable discretion of the general counsel in this area, courts are similarly precluded from resolving the issue. *See, e.g.*, United Elec. Contractors Ass'n v. Ordman, 366 F.2d 776 (2nd Cir. 1966), *cert. denied*, 385 U.S. 1026 (1967). *See also* Anthony v. NLRB, 204 F.2d 832 (6th Cir. 1953); Manhattan Constr. Co. v. NLRB, 198 F.2d 320 (10th Cir. 1952); Lincourt v. NLRB, 170 F.2d 306 (1st Cir. 1948). When such a fundamental statutory question is involved, the general counsel should resolve any possible doubts in favor of a complaint, so that the labor board, and ultimately the appellate courts, will be able finally to determine the matter. See Sections 10(e)-(f), 29 U.S.C. §§ 160(e)-(f) (1970).

57. See note 38 & accompanying text *supra*.

58. *See General Counsel Hospital Report*, 88 LAB. REL. REP. 8, 12-13 (1975).

59. *Id.* The general counsel determined that the medical staff bylaws pertaining to the functioning of the utilization review committee provided the physician-members with complete autonomy concerning their review decisions. He therefore concluded that the hospital not only exercised no control over the "means" used to operate the committee, but actually had little influence upon the "ends" to be achieved. *Id.* at 13.

60. *Malpractice, supra* note 26, at 957.

61. See text accompanying note 48 *supra*.

resolved by examining the control which the hospital exerts over the professional work of the staff doctors. Examination of the relationship in terms of the *non*control elements is inconclusive, as four of the factors support an independent contractor determination, while the other four favor an employment conclusion.[62]

Staff physicians are undoubtedly engaged in a distinct occupation. Furthermore, their profession entails an extremely high degree of skill.[63] Such doctors are generally compensated for the job performed, rather than by the hour or week.[64] It is also clear that staff doctors and their hospitals have traditionally believed that they were creating an independent contractor relationship rather than an employment relationship.[65]

On the other hand, it is the hospital which generally provides the instrumentalities, tools, and major place of work for the staff doctors. The relationship is of an indefinite, continuing nature. Moreover, the modern hospital is not only engaged in a vast business enterprise, but also commonly regarded as being a comprehensive health care center,[66] which indicates that the staff physicians perform work which contributes significantly to the regular business of the institution. Therefore, to resolve the inconclusive results of this evaluation, it is necessary to examine the degree of control and supervision actually exercised by the hospital over its staff doctors.

Staff physicians were traditionally considered to be independent contractors who merely used the facilities provided by hospitals; the hospitals exercised little, if any, control over the professional services

62. The two "control" factors are number (1), which pertains to the control the master may exercise over the details of the work, and number (3) which concerns the amount of direction or supervision generally exercised by the master in the geographic locality over the type of occupation involved.

63. It should be noted that merely because staff physicians practice a distinct occupation involving a high degree of skill does not necessarily indicate the presence of an independent contractor relationship. These characteristics are usually present with respect to all professional workers, yet the NLRA expressly recognizes that such professional personnel may well be employees since it establishes special unit determination rights for them. See NLRA § 9(b)(1), 29 U.S.C. § 159(b)(1) (1970). See also Leedom v. Kyne, 358 U.S. 184 (1958). For the statutory definition of "professional employee" see NLRA section 2(12), 29 U.S.C. section 152 (12) (1970).

64. The fact that staff doctors are presently not paid by hospitals for their professional work should not be controlling, since they provide an integral service without which the health care institution could not function. Furthermore, should staff physicians be provided with NLRA protection, it is likely they will demand compensation from their hospitals when their work inures to the benefit of the institutions.

65. See note 3 & accompanying text *supra*.

66. See note 4 & accompanying text *supra*.

performed by these doctors.[67] In recent years, however, health care institutions have begun to exert much greater authority over their staff physicians. The professional staff of a modern hopital is generally organized into various committees.[68] These professional staff committees are usually composed primarily of practitioners, and the courts have recognized that such committee members act as agents of the institution during the performance of their adminstrative work.[69] This situation creates the presence of "a vastly different relationship between the corporate institution and the practicing physician than is suggested by the historical distinction separating 'hospital' and 'medical' services."[70]

Several relatively recent developments have provided hospitals with significant impetus to increase substantially the degree of supervision which they exercise over the professional work performed by their staff physicians. Medicare and Medicaid regulations require hospitals to review the medical services provided by their staff practitioners to eligible beneficiaries.[71] In addition, as the general public has increasingly come to regard hospitals as comprehensive health care institutions which they may visit whenever they require major medical treatment, they have commensurately begun to expect institutionally-imposed quality control:

> Public outrage, and possibly even an effect on admissions at a typical hospital, would surely follow a public announcement by the hospital that it regards all staff doctors as completely independent professionals, conducts no supervision of their performance and takes no interest in their competence. The public assumes . . . that the hospital exerts some measure of control over the medical activities taking place there.[72]

Finally, recent judicial decisions concerning the legal responsiblity of hospitals for the medical malpractice of their staff doctors almost mandate considerable institutional control over the medical services provided in such facilities. In the landmark case of *Darling v. Charles-*

67. *See* Southwick, *supra* note 4, at 434. See notes 2-3 & accompanying text *supra.*

68. *See Staff Privileges, supra* note 51, at 903.

69. Note, *Hospital Liability for the Negligence of Physicians: Some Needed Legal Sutures,* 26 U. FLA. L. REV. 844, 848 (1974); see cases cited *id.* n.39. Not only do the hospital committees perform a necessary service for the institution (see note 10 & accompanying text *supra*), but they also usurp an ever increasing amount of the staff members' time. *See* 1 REPORT OF THE NATIONAL ADVISORY COMMISSION ON HEALTH MANPOWER 14 (1967).

70. Southwick, *supra* note 4, at 435.

71. Hanson & Stromberg, *supra* note 27, at 27. See notes 8-13 & accompanying text *supra.* To satisfy these requirements, most large hospitals have already established the administrative apparatus needed to monitor effectively the staff members' medical performance. *Malpractice, supra* note 5, at 965.

72. *Malpractice, supra* note 26, at 967.

ton Community Memorial Hospital,[73] the Illinois Supreme Court not only upheld hospital liability for the injury suffered by Mr. Darling because of the inadequate care provided by the nurses, but also ruled that the hospital had failed to review sufficiently the medical treatment rendered to the patient by the attending staff physician.[74] The *Darling* court thereby recognized the obligation of a modern hospital to supervise and control, at least minimally, the professional conduct of its staff doctors. Since that decision, other courts have demonstrated an inclination to require similar supervision by hospitals of the medical performance of their staff practitioners.[75]

As the modern trend toward hospital tort liability continues, it should become apparent "that the responsibility of lay hospital boards of governors extends even to the quality of medical care in the hospital, including the actions . . . even of the medical staff, not only in so-called administrative actions, but in medical care of patients.[76] Under such circumstances, the degree of control and supervision exercised by the hospital over its staff physicians is more consistent with an employment relationship than it is with a traditional independent contractor relationship. The institution is not merely directing the staff practitioner to complete an assigned task satisfactorily; rather, it is actually accepting the responsibility for supervising and, where necessary to protect the

73. 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966). Mr. Darling went to the hospital emergency room for treatment of a broken leg. There he was attended by the staff doctor on call. He was subsequently admitted to the hospital as a patient of that staff physician. While he was in the hospital, a constricted cast caused circulatory difficulties and substantial pain. The hospital nurses, who had failed to monitor the patient's progress, did not inform the hospital administration of the patient's suffering, nor did the attending staff practitioner take appropriate precautionary measures. As a result, the leg had to be amputated below the knee.

74. 33 Ill. 2d at 333, 211 N.E.2d at 258.

75. *See* Woodbury v. McKinnon, 447 F.2d 839 (5th Cir. 1971); Purcell v. Zimbelman, 18 Ariz. App. 75, 500 P.2d 335 (1972); Joiner v. Mitchell County Hospital Auth., 125 Ga. App. 1, 186 S.E.2d 307 (1971), *aff'd*, 229 Ga. 140, 189 S.E.2d 412 (1972); Moore v. Board of Trustees of Carson-Tahoe Hosp., 88 Nev. 207, 495 P.2d 605, *cert. denied*, 409 U.S. 879 (1972); Fiorentino v. Wenger, 19 N.Y.2d 407, 227 N.E.2d 296, 280 N.Y.S.2d 373 (1967); Pederson v. Dumouchel, 72 Wash. 2d 73, 431 P.2d 973 (1967). *See also* Hanson & Stromberg, *supra* note 27, at 13; Note, *Unnecessary Surgery: Doctor and Hospital Liability*, 61 GEO. L.J. 807, 814 (1973); Comment, *Hospital Liability—A New Duty of Care*, 19 MAINE L. REV. 102, 109-10 (1967). In several states, hospital responsibility for reviewing the quality of medical care is mandated by statute. *See, e.g.*, ARIZ. REV. STAT. ANN. § 36-445 (1971); IND. ANN. STAT. CODE § 16-10-1-6.5 (Burns 1973); MICH. COMP. LAWS ANN. § 331.422 (West Supp. 1975).

76. Fabro, *Legal Relationship of Physician to Hospital*, 43 CONN. B.J. 418, 424 (1969). *See generally* Raymond, *Regulation of Medical Care Rendered by Private Physicians to Hospitalized Patients*, 30 J. MO. B. 93 (1974).

rights of the patient, is even regulating the on-going professional performance of the doctor.

In the future, the labor board should be exceedingly careful to evaluate all the specific factors inherent in a particular staff physician-hospital relationship before it accepts the traditional, yet possibly outdated, notion that only an independent contractor relationship is involved. The NLRB should at least recognize the reasonable probability that an employment relationship exists with respect to staff doctors who are required to serve on hospital committees, since the performance of vital committee work is often subject to the actual control of the hospital administration.[77] Furthermore, in those increasing instances in which the institution meaningfully supervises and regulates the actual medical services provided by staff physicians, the NLRB should be willing to recognize the contemporary realities of the situation and accord such hospital employees[78] the benefits and protections of the NLRA.[79]

77. An employment finding with respect to committee work would afford the physicians NLRA coverage for the performance of their committee assignments. The hospital, as their committee employer, would be obligated to bargain with the appropriately designated employee representative with respect to the wages, hours, and other terms and conditions of *committee* employment. See note 38 & accompanying text *supra*. While the specter of such committee-oriented bargaining initially may seem strange to some, it should be noted that there have already been several collective bargaining agreements negotiated which cover only the hospital committee work of staff physicians. *See, e.g.*, Agreement Between Nevada Physicians Union, Local 676, SEIU, AFL-CIO, and Valley Hospital, Ltd. (Sept. 1, 1972). (A copy of this agreement is in the author's possession.) As expanding committee responsibilities detract from the medical practices of the staff doctors involved, there will be increasing pressure upon hospitals to compensate committee members for their services.

78. If courts are prepared to recognize the existence of employment relationships in such situations for tort liability purposes, there is no rational basis for denying the same employees NLRA coverage.

Since NLRA section 2(3), 29 U.S.C. section 152(3) (1970), expressly excludes supervisors from the statutory definition of employee, it is quite possible that health care institutions will assert that staff physicians who direct the work of hospital attendants and nurses should be considered supervisory personnel who are not entitled to NLRA coverage. Such an argument, however, should generally be rejected. Section 2(11) of the labor act provides in relevant part: "The term 'supervisor' means any individual having authority, *in the interest of the employer*, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively to recommend such action . . . ." NLRA § 2(11), 29 U.S.C. § 152(11) (1970) (emphasis added). Although staff doctors would usually not possess the authority to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, discipline, or adjust the grievances of other hospital personnel, they would frequently have the right, particularly during surgical operations, to direct the work of the ancillary employees. Nevertheless, this necessary function should not be sufficient to deprive the physicians of employee status. The direction of such people would be done on behalf of themselves and their patients only, rather than on behalf of the medical facility, and it would merely involve that degree of control required for the

Physician-Employees of Private[80] Employers Outside NLRB Jurisdiction

Under section 14(c)(2) of the NLRA,[81] states are permitted to exercise labor jurisidction over private employers who are not subject to the jurisdictional purview of the labor board.[82] This state jurisdiction

accomplishment of their professional obligation to their patients. The propriety of this analysis has been recognized by the labor board which "has carefully avoided applying the definition of 'supervisor' to a health care professional who gives direction to other employees in the exercise of professional judgment, which direction is incidental to the professional's treatment of patients, and thus is not the exercise of supervisory authority in the interest of the employer." Wing Memorial Hospital Ass'n, 217 N.L.R.B. No. 172, 89 L.R.R.M. 1183 (1975), slip op. at 4. See S. REP. No. 93-766, 93d Cong., 2nd Sess. 6 (Apr. 2, 1974), in which Congress acknowledged the labor board's practice in this regard. Therefore, in the absence of other indicia of "supervisory" authority, staff physicians should not be considered to be supervisory personnel.

79. Staff physicians generally employed by a hospital would desire negotiations concerning their working conditions at the hospital. They might also seek a grievance procedure regarding actions taken by the institution's reviewing authority with respect to their professional performance. Other relevant topics of mutual concern would constitute additional appropriate subjects for bargaining.

80. It should be noted that salaried physicians employed by *public* entities are entitled to certain labor relations benefits. All doctors who are nonsupervisory employees of a department or agency of the federal government, such as a Veterans' Administration hospital, are provided with substantial labor rights and protections under Exec. Order No. 11491, 3 C.F.R. 861 (1971). Section 1 guarantees such employee-physicians organizational rights similar to those delineated in section 7 of the NLRA (see note 33 & accompanying text *supra*), while section 19(a) affords them protections analogous to those described in sections 8(a)(1), 8(a)(3), and 8(a)(5) of the NLRA (see notes 34-38 & accompanying text *supra*). *See* Fasser, *The Right to Union Representation Under Executive Order 11491*, 25 LAB. L.J. 531 (1974). *See also* Exec. Order No. 11838, 40 Fed. Reg. 5743 (Feb. 7, 1975) which amends Exec. Order No. 11491. *See generally* R. SMITH, H. EDWARDS & T. CLARK, LABOR RELATIONS LAW IN THE PUBLIC SECTOR (1974). Nevertheless, unlike their private sector counterparts, who are specifically guaranteed the right to strike under section 13 of the NLRA, employees of the federal government are expressly prohibited from engaging in any work stoppage. United Fed'n of Postal Clerks v. Blount, 325 F. Supp. 879 (D.D.C.), *aff'd mem.*, 404 U.S. 802 (1971). *Compare* 29 U.S.C. § 163 (1970) *with* 5 U.S.C. §§ 3333, 7311 (1970) *and* 18 U.S.C. § 1981 (1970).

Physicians employed by any local government, district, or department in California are provided with similar rights and protections under the Meyers-Milias-Brown Act. CAL. GOV'T CODE §§ 3501-10 (West 1966 & Supp. 1975). Instead of full collective bargaining rights, however, they are permitted only "meet and confer" privileges. *Id.* § 3505 (West 1966 & Supp. 1975). Coverage analogous to that available under the Meyers-Milias-Brown Act is also accorded physicians employed by an agency, department, or commission of the State of California. *Id.* §§ 3525-36 (West 1966). No public employees in California may engage in any strike.

81. 29 U.S.C. § 164(c)(2) (1970).

82. Prior to the enactment of section 14(c)(2) in 1959, states were preempted from asserting jurisdiction over labor practices affecting interstate commerce but failing to satisfy the NLRB's jurisdictional requirements. *See* Guss v. Utah Labor Relations Bd., 353 U.S. 1 (1956).

includes not only employers engaged in business usually subject to labor board jurisdiction who are excluded from coverage owing to their failure to satisfy the NLRB's monetary jurisdiction standards,[83] but also employers who perform functions considered by the board to be wholly local in nature. For example, the NLRB recently indicated that it will not assert jurisdiction over law firms, since it does not believe that they have a sufficient impact upon interstate commerce to warrant NLRA coverage.[84] Similar reasoning may well induce the labor board to decline jurisdiction over physicians engaged in group practices.[85] In light of contemporary developments indicating that there will soon be a substantial proliferation of these medical practices in the form of health maintenance organizations,[86] it becomes important to consider the labor protections afforded to employees of such private concerns under California law.[87]

Preferring to leave the resolution of labor disputes to the free interaction of economic forces, California has generally adopted a laissez-faire policy with respect to labor relations in the private sector.[88] This position generally permits a labor organization to engage in any nonviolent activity which does not contravene a specific state policy. Unfortunately, however, no procedures have been established by which employees may peacefully require their employer to recognize and negotiate with their duly designated bargaining representative.

Nevertheless, some minimal protection is afforded to employees. The language of section 923 of the California Labor Code provides that a worker

83. See note 32 *supra.*

84. Bodle, Fogel, Julber, Reinhardt & Rothschild, 206 N.L.R.B. 60 (1973); *see* Note, *NLRB Declines to Assert Jurisdiction Over Law Firms,* 41 TENN. L. REV. 745 (1974); Note, *Legal Services Have Insufficient Effect on Interstate Commerce to Justify Exercise of NLRB Jurisdiction,* 7 LOYOLA L. REV. (Los Angeles) 385 (1974).

85. Since medical practices are usually confined to relatively limited geographical areas, while legal enterprises frequently involve matters which transcend local boundaries, it appears that local group medical practices have a less significant impact than law firms upon interstate commerce.

86. See notes 14-20 & accompanying text *supra.*

87. Although many of the physicians presently associated with such medical groups enjoy nonemployee, partnership status, a few salaried doctors are already connected with such entities as employees. *Prepaid Group Practice, supra* note 14, at 904-05 & n.9. As these programs expand, it is likely that more employment relationships involving physicians will be created.

88. *See* Englund v. Chavez, 8 Cal. 3d 572, 584, 504 P.2d 457, 465, 105 Cal. Rptr. 521, 529 (1972); Petri Cleaners, Inc. v. Automotive Employees Local 88, 53 Cal. 2d 455, 469, 349 P.2d 76, 85, 2 Cal. Rptr. 470, 479 (1960).

> shall be free from the interference, restraint, or coercion of employers of labor, or their agents, in the designation of such representatives or in self-organization or in other concerted activities for the purpose of collective bargaining or other mutual aid or protection.[89]

This provision has been interpreted to mean that an employer may not discharge or otherwise interfere with an employee solely because of his membership in, or activity on behalf of, a labor organization, or in response to his selection of a bargaining representative.[90] Nonetheless, section 923 does not specifically impose any further restrictions upon employer conduct. For example, since section 923 specifices only that "negotiation of terms and conditions of labor should result from voluntary agreement between employer and employees,"[91] it is recognized that an employer is *not required* by law to engage in collective bargaining with a union, even if it actually represents a majority of the employees involved.[92] Therefore, so long as an employer of physicians does not interfere with their exercise of the rights specified in section 923, that employer is legally permitted to ignore the efforts of such employees to establish a collective bargaining relationship with him. Should the employed doctors be in a position to exert significant economic pressure on their employer, however, they may still be able to achieve the desired negotiating objectives, provided they do not engage in conduct proscribed by other federal or state provisions.

Since physicians who are desirous of exerting united economic pressure against those entities which substantially control their economic destinies will necessarily have to engage in concerted activity, they may very possibly encounter antitrust difficulties, unless they can demonstrate the inapplicability of such laws to their conduct. It therefore becomes imperative to consider the impact of the federal and state antitrust provisions upon physician organizing efforts.

Antitrust Considerations

A bifurcated analysis is necessary to a discussion of potential, antitrust liability. The first inquiry concerns whether certain contemplated activities would constitute *substantive* violations of federal or California antitrust provisions. Then, if a specific substantive violation is

89. CAL. LABOR CODE § 923 (West 1971).

90. *See* Montalvo v. Zamora, 7 Cal. App. 3d 69, 86 Cal. Rptr. 401 (1970); Glenn v. Clearman's Golden Cock Inn, Inc., 192 Cal. App. 2d 793, 13 Cal. Rptr. 769 (1961).

91. CAL. LABOR CODE § 923 (West 1971).

92. *See* Petri Cleaners, Inc. v. Automotive Employees Local 88, 53 Cal. 2d 455, 469-74, 349 P.2d 76, 85-88, 2 Cal. Rptr. 470, 479-82 (1960).

established, it becomes necessary to evaluate the possible applicability of one or more of the recognized *exemptions* from the antitrust laws.

Substantive Antitrust Ramifications

Although the California Cartwright Antitrust Act[93] applies to all restraints of trade involving California business, while the federal Sherman Antitrust Act[94] covers only those restraints which meaningfully affect interstate or foreign commerce,[95] it is generally recognized that the two statutes proscribe the same basic forms of activity. Therefore, the areas of common substantive coverage will be discussed first; an analysis of the Sherman Act's interstate commerce requirement will follow.

Activities Permitted and Prohibited Under the Sherman and Cartwright Acts

The relevant portion of the federal Sherman Act proscribes "[e]very contract, combination . . . or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations."[96] Although the pertinent language of the California Cartwright Act[97] is quite different from that contained in section 1 of the Sherman Act, it has generally been interpreted as prohibiting the same types of restraints upon trade. The Cartwright Act was patterned after the Sherman Act; both have their roots in the common law. Thus it is recognized that federal court decisions interpreting the substantive portions of the Sherman Act are persuasive authority with respect to Cartwright Act cases.[98]

At the outset, it is important to emphasize the fact that both antitrust statutes proscribe only combinations and conspiracies. Wholly individual conduct is not restricted.[99] Therefore, so long as an individual

93. CAL. BUS. & PROF. CODE §§ 16700-16758 (West 1964 & Supp. 1975).

94. 15 U.S.C. §§ 1-7 (1970). *See also* Clayton Act, 15 U.S.C. §§ 12, 14-31 (1970); Federal Trade Commission Act, 15 U.S.C.A. §§ 41-43, 45-48 (1973 & Pamphlet No. 1, 1975).

95. See text accompanying notes 119-38 *infra.*

96. 15 U.S.C.A. § 1 (1973) *as amended* (Pamphlet No. 1, 1975).

97. CAL. BUS. & PROF. CODE § 16720 (West 1964).

98. *See* Corwin v. City of Los Angeles Newspaper Service Bureau, Inc., 4 Cal. 3d 842, 484 P.2d 953, 94 Cal. Rptr. 785 (1971); Chicago Title Ins. Co. v. Great W. Fin. Corp., 69 Cal. 2d 305, 444 P.2d 481, 70 Cal. Rptr. 849 (1968). *See generally* Von Kalinowski & Hanson, *California Antitrust Laws: A Comparison with the Federal Antitrust Laws*, 6 U.C.L.A.L. REV. 533 (1959).

99. This conclusion, of course, assumes that the individual in question does not possess monopoly power. *See* 15 U.S.C.A. § 2 (1973) *as amended* (Pamphlet No. 1, (1975)). Single physicians could seldom (and then only in the case of a unique and

practitioner acts alone, and not in concert or combination with other physicians or groups, his actions would not fall within the coverage of either the Sherman Act or the Cartwright Act. This right provides an individual doctor with the opportunity legally to refuse to deal with any party with whom he does not wish to have professional contact.[100] For example, if an individual physician is not satisfied with the conditions an insurance carrier intends to impose upon his handling of a particular case, he may simply refuse to provide his professional services to the patient in question, leaving the insurance carrier to locate a different doctor.[101] Similarly, if a single practitioner is unhappy in his relationship with a certain hospital, he may legitimately decide to terminate his relations with that institution.[102]

Although an individual doctor may not, acting alone, possess sufficient power to affect meaningfully the policies of large organizations such as hospitals and insurance carriers, he may not be the only party who is actively demonstrating his dissatisfaction. If one physician is sufficiently incensed to refuse to begin or continue a disadvantageous relationship, there is substantial likelihood that other individual doctors will resort to similar action. Whenever hospitals or insurance carriers are imposing truly unreasonable conditions, there is a significant possibility that individual action by many independent doctors will encourage those organizations to reconsider seriously their opprobrious policies.

An important caveat must always be considered, however, with respect to "individualistic" conduct. So long as a physician acts completely alone, he is protected from antitrust liability. Nevertheless, if

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revolutionary method) possess sufficient market power to precipitate monopolization considerations. *See, e.g.*, United States v. Grinnell Corp., 384 U.S. 563 (1966); International Boxing Club v. United States, 358 U.S. 242 (1959); United States v. E.I. duPont de Nemours & Co., 351 U.S. 377, 395 n.23 (1956).

100. *See* United States v. Colgate & Co., 250 U.S. 300 (1919); *cf.* United States v. Park Davis & Co., 362 U.S. 29 (1960). *See also* 1 HANDLER, TWENTY-FIVE YEARS OF ANTITRUST 444-48 (1973); Dam & Pitofsky, *Debate: Is the Colgate Doctrine Dead?*, 37 ANTITRUST L.J. 772 (1968); Halper, *Individual Refusals to Deal: Customer Selection or Dealer Protection?*, 22 A.B.A. SECT. ANTITRUST L. 49 (1963); Turner, *The Definition of Agreement Under the Sherman Act: Conscious Parallelism and Refusals to Deal*, 75 HARV. L. REV. 655 (1962).

101. Insurance carriers currently pay for over two-thirds of the nation's medical expenses (see note 5 *supra*). Therefore, if the conditions causing the doctor's consternation are typical of those generally imposed by all such carriers, a physician's decision not to perform services for patients insured by these carriers could easily have a substantial adverse impact on the overall earnings of that doctor.

102. Of course, when there is only one major medical facility in the geographical area in which the physician practices, this alternative may not be practically available to him.

there is meaningful evidence that he is in fact acting pursuant to some concerted plan or scheme, his protection will be forfeited.[103] A physician must therefore be extremely careful not to encourage other practitioners to engage in similar "individual" behavior, since such encouragement might possibly be sufficient to establish the existence of the proscribed combination or conspiracy. As a consequence, physician unions and associations would be precluded from expressly or impliedly inducing or encouraging action by their members, unless they could otherwise demonstrate the inapplicability of the antitrust laws to their concerted endeavors.

Not all combinations or conspiracies which impose restrictions upon trade or commerce are illegal. The United States Supreme Court has recognized that only "*unreasonable*" restraints are proscribed by the Sherman Act.[104] The California courts have similarly interpreted the Cartwright Act as prohibiting only unreasonable restrictions.[105] Therefore, concerted activity which has a legitimate objective, unrelated to any intention to restrain trade, and which only incidentally inhibits business, will usually not be found violative of the Sherman and Cartwright acts. For example, it would probably be permissible for a physician organization to induce California industrial accident insurance carriers to agree to resolve all questions concerning the fees they will pay physicians in particular workers' compensation cases through direct negotiation with the individual practitioner involved, rather than by having such carriers unilaterally impose their own fee schedules upon the doctors. This arrangement would encourage free and open business dealings between the participating insurance carriers and individual physicians, and would effect, at most, a *de minimis* restraint on trade. Furthermore, such individually negotiated fee schedules are specifically contemplated by section 5304 of the California Labor Code, which provides that the

103. *See, e.g.*, United States v. General Motors Corp., 384 U.S. 127 (1966); Interstate Circuit, Inc. v. United States, 306 U.S. 208 (1939); Flintkote Co. v. Lysfjord, 246 F.2d 368, 374 (9th Cir.), *cert. denied*, 355 U.S. 835 (1957). *But see* Theatre Enterprises, Inc. v. Paramount Film Distrib. Corp., 346 U.S. 537 (1954); Kline v. Coldwell, Banker & Co., 508 F.2d 226, 232-33 (9th Cir. 1974); Independent Iron Works, Inc. v. United States Steel Corp., 322 F.2d 656 (9th Cir.), *cert. denied*, 375 U.S. 922 (1963); Delaware Valley Marine Supply Co. v. American Tobacco Co., 297 F.2d 199 (3rd Cir. 1961), *cert. denied*, 369 U.S. 839 (1962). *See generally* Turner, *The Definition of Agreement Under the Sherman Act: Conscious Parallelism and Refusals to Deal*, 75 HARV. L. REV. 655 (1962).

104. *See* Standard Oil Co. v. United States, 221 U.S. 1 (1911).

105. *See* People v. Building Maintenance Contractors' Ass'n, 41 Cal. 2d 719, 727, 264 P.2d 31, 36-37 (1953); Milton v. Hudson Sales Corp., 152 Cal. App. 2d 418, 313 P.2d 936 (1957).

Workers' Compensation Appeals Board (WCAB) has jurisdiction over any controversy concerning the fees to be paid to physicians who perform services in industrial accident cases, "unless an express agreement fixing the amounts to be paid for medical, surgical or hospital treatment . . . has been made between the persons or institutions rendering such treatment and the employer or insurer."[106] It is important to recognize, however, that a physician organization and insurance carriers could *not* agree upon the actual fees which are to be paid to individual physicians, for this type of concerted arrangement would constitute a clear antitrust violation.

Certain concerted activities are considered to have so pernicious an effect upon trade that they constitute per se violations of the Sherman Act, regardless of any protestations of reasonableness. For example, price-fixing agreements involving competitors have traditionally been considered illegal per se; the arguably reasonable nature of these arrangements is viewed as irrelevant.[107] Similarly, concerted refusals to deal and group boycotts have historically been condemned as per se violations of the Sherman Act.[108] It is interesting to note, however, that while group boycotts and concerted refusals to deal have also been considered to be per se violations of the Cartwright Act,[109] the current status of price-fixing arrangements under the California antitrust statute is not wholly clear.

In *Herriman v. Menzies*,[110] a pre-Cartwright Act case which was decided under the common law, the California Supreme Court held that a price-fixing agreement which had been entered into by only a few members of a particular industry was legal, since there was no demonstration that the prices agreed upon were unreasonable or that there was

106. CAL. LABOR CODE § 5304 (West 1971). It is established that when such an express agreement has been entered into between an individual physician and the injured worker's employer or the employer's insurance carrier, that contractual obligation may be enforced in an action at law. *See, e.g.*, Independence Indem. Co. v. Industrial Accident Comm'n, 2 Cal. 2d 397, 41 P.2d 320 (1935); Tomlinson v. Superior Ct., 66 Cal. App. 2d 640, 152 P.2d 517 (1944).

107. *See, e.g.*, Goldfarb v. Virginia State Bar, 43 U.S.L.W. 4723, 4726 (June 16, 1975); Citizen Publishing Co. v. United States, 394 U.S. 131, 135 (1969); United States v. Masonite Corp., 316 U.S. 265, 276 (1942); United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 223 (1940).

108. *See, e.g.*, White Motor Co. v. United States, 372 U.S. 253, 263 (1963); Klor's, Inc. v. Broadway-Hale Stores, Inc., 359 U.S. 207, 212 (1959); Fashion Originators' Guild of America v. FTC, 312 U.S. 457, 465 (1941). *See generally* Barber, *Refusals to Deal Under the Federal Antitrust Laws*, 103 U. PA. L. REV. 847 (1955).

109. *See* People v. Inland Bid Depository, 233 Cal. App. 2d 851, 860, 44 Cal. Rptr. 206, 212 (1965).

110. 115 Cal. 16, 46 P.730 (1896).

any interference with the freedom of others to engage in that trade. Nevertheless, subsequent cases, decided under the Cartwright Act, have specifically questioned the continuing validity of the rationale applied in *Menzies*.[111] Although these Cartwright Act cases have expressly indicated that price-fixing by competitors who dominate an industry constitutes an unlawful restraint of trade, it is unclear whether a price-fixing arrangement is presently illegal under that act regardless of the amount of market control exercised by the involved competitors.[112] It appears that the membership of any physician organization which could represent its members effectively in their dealings with insurance carriers, governmental agencies, or health care institutions would necessarily constitute a significant portion of the relevant medical practitioner market in California; consequently, any price-fixing activity involving that group would be illegal under the Cartwright Act.[113]

Although a labor organization composed of medical practitioners might reasonably be expected to concern itself with many social and professional issues which transcend the typical worker-employer relationship, it is still obvious that many physicians are likely to form and participate in doctor unions for the purpose of enhancing their economic position vis-à-vis the well organized health care industry, which includes hospitals, insurance carriers, and Medicare and MediCal agencies.[114] A physician organization which is unable to immunize its conduct under one of the recognized exemptions to the antitrust laws[115] would have to refrain from any activity aimed at achieving a price-fixing arrangement among its members alone or involving other entities, as well. A price-establishing agreement negotiated between a physician union and an institution which remunerates doctors for their professional services would violate the Sherman and Cartwright acts,[116] in the absence of an applicable exemption. Furthermore, should a physician organization, in an effort to enhance its negotiating position, resort to labor's traditional bargaining weapon, the work stoppage, this conduct would most likely

111. *See, e.g.*, People v. Building Maintenance Contractors' Ass'n, 41 Cal. 2d 719, 264 P.2d 31 (1953).

112. *See* 33 CAL. JUR. 2d *Monopolies* § 11 (1957).

113. Support for this conclusion may also be derived from the fact that physicians may reasonably be considered to perform a vital public service. *See, e.g.*, Coombs v. Burke, 40 Cal. App. 8, 180 P.59 (1919).

114. See notes 5-13 & accompanying text *supra*.

115. See text accompanying notes 139-94 *infra*. *See also* text accompanying notes 119-38 *infra*, regarding the commerce requirement of the Sherman Act.

116. Collective bargaining contracts can clearly constitute antitrust violations under appropriate circumstances. *See, e.g.*, Allen Bradley Co. v. IBEW Local 3, 325 U.S. 797 (1945). See notes 107, 110-13 & accompanying text *supra*.

be considered a boycott or concerted refusal to deal, which would automatically be proscribed by the antitrust laws,[117] unless the organization were able to avail itself of the protection of one of the established exemptions.[118] For this reason, it is necessary to examine not only the historically developed antitrust exemption doctrines, but also the interstate commerce requirement of the Sherman Act.

Interstate Commerce Requirement For Shertman Act Applicability

Although the Cartwright Act applies to all unreasonable restraints of trade imposed upon California business, it is clear that section 1 of the Sherman Act[119] merely pertains to those business restraints which meaningfully affect interstate or foreign commerce. In an antitrust action brought under the Sherman Act, the plaintiff must affirmatively demonstrate the requisite effect upon interstate commerce as a condition to recovery.

The interstate commerce requirement of the Sherman Act may be satisfied in either of two ways. It may be established that the activity complained of occurred *within* interstate commerce.[120] Alternatively, the plaintiff may show that while the acts in question were themselves local or intrastate in nature, they directly and substantially *affected* interstate

117. See notes 108-09 & accompanying text *supra*. Even though the insurance carrier or health care institution affected may not be in competition with the practitioner-members of the physician organization, concerted boycott activities would still be violations of the antitrust laws. *See, e.g.*, Klor's Inc. v. Broadway-Hale Stores, Inc., 359 U.S. 207 (1959); Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc., 340 U.S. 211 (1951). *See also* Note, *Antitrust Law-Group Boycotts—Private Associations*, 21 CASE W. RES. L. REV. 314 (1970).

118. Antitrust laws would not prevent organized physicians from approaching governmental officials in an effort to induce them to take action which would be beneficial to medical practitioners, even though such action might have an adverse impact upon parties engaged in trade or commerce. *See* United Mine Workers v. Pennington, 381 U.S. 657, 669-71 (1965); Eastern R.R. Presidents Conference v. Noerr Motor Freight Co., 365 U.S. 127 (1961); *cf.* California Motor Transp. Co. v. Trucking Unlimited, 404 U.S. 508 (1972). *See also* Note, *Application of the Sherman Act to Attempts to Influence Government Action*, 81 HARV. L. REV. 847 (1968); Note, *Solicitation of Governmental Action in Restraint of Trade—Noerr Revisited*, 8 HOUST. L. REV. 952 (1971). It would thus be permissible for a physician organization to use legal means to convince the Administrative Director who establishes the minimum fee schedule for industrial accident cases in California to promulgate a minimum compensation schedule which is acceptable to medical practitioners. Other such lobbying efforts directed toward favorable action by public officials would similarly be protected.

119. See text accompanying note 96 *supra*.

120. *See, e.g.*, United States v. Shubert, 348 U.S. 222 (1955); Lorain Journal Co. v. United States, 342 U.S. 143 (1951); Swift & Co. v. United States, 196 U.S. 375 (1905).

commerce.[121] Therefore, were a "national" or "international" physician organization, such as the American Federation of Physicians and Dentists, to negotiate a price-fixing agreement having multistate applicability, the "in commerce" requirement of the Sherman Act would ipso facto be satisfied.[122] In the more likely event, however, that a wholly intrastate fee arrangement were collectively bargained by a physician union, the requisite jurisdictional standard would have to be established by demonstrating that the agreement directly and substantially affected interstate commerce.[123]

It is well recognized that some entirely local activities, in which none of the participants is involved directly in interstate business, may nevertheless have the requisite effect upon commerce, for "[i]f it is interstate commerce that feels the pinch, it does not matter how local the operation which applies the squeeze."[124] The quality of the effect, however, must always be evaluated:

> [D]espite the increased thrust of federal commerce power as business operations become more interrelated and complex, the courts have consistently required that in order for federal antitrust jurisdiction to be sustained the effect on interstate commerce of an alleged antitrust violation in a local area must be *direct and substantial, and not merely inconsequential, remote or fortuitous.*[125]

The mere fact that an intrastate fee arrangement involves insurance carriers or hospitals engaged in interstate commerce does not automatically demonstrate the required effect upon interstate commerce: "The test of jurisdiction is not that the acts complained of affect a business engaged in interstate commerce, but that the conduct complained of affects the interstate commerce of such business."[126]

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121. *See, e.g.*, Burke v. Ford, 389 U.S. 320 (1967); United States v. Employing Plasterers Ass'n, 347 U.S. 186 (1954); United States v. Women's Sportswear Mfrs. Ass'n, 336 U.S. 460 (1949). *See generally* Eiger, *The Commerce Element in Federal Antitrust Litigation*, 25 FED. B.J. 282 (1965); Kallis, *Local Conduct and the Sherman Act*, 1959 DUKE L.J. 236.

122. See note 120 *supra.*

123. See cases cited at note 121 *supra.*

124. United States v. Women's Sportswear Mfrs. Ass'n, 336 U.S. 460, 464 (1949). *See* Page v. Work, 290 F.2d 323, 332 (9th Cir.), *cert. denied*, 368 U.S. 875 (1961). *See also* Goldfarb v. Virginia State Bar, 43 U.S.L.W. 4723, 4726-27 (June 16, 1975).

125. Page v. Work, 290 F.2d 323, 332 (9th Cir.), *cert. denied*, 368 U.S. 875 (1961) (emphasis added); *see* Mandeville Island Farms, Inc. v. American Crystal Sugar Co., 334 U.S. 219, 234 (1948).

126. Page v. Work, 290 F.2d 323, 330 (9th Cir.), *cert. denied*, 368 U.S. 875 (1961); *see* Yellow Cab Co. v. Cab Employers Local 881, 457 F.2d 1032, 1034 (9th Cir. 1972).

In *John Kalin Funeral Home, Inc. v. Fultz*,[127] the court held that a group of morticians who conspired to monoplize the mortuary business within a particular county did not sufficiently affect interstate commerce to bring their otherwise proscribed activity within the jurisidictional purview of the Sherman Act. The shipment of some bodies to and from the state of Washington failed to provide the requisite effect, since such activity was only incidental to the morticians' general business. A similar conclusion was reached in *Sun Valley Disposal Co. v. Silver State Disposal Co.*,[128] in which the court refused to find Sherman Act jurisdiction with respect to a conspiracy among local refuse dealers which detrimentally affected the plaintiff, despite the fact that the plaintiff had been engaged in the business of leasing containers which it obtained from out of state. Furthermore, the court in *Sun Valley Disposal* deemed not controlling the fact that the plaintiff also engaged in business in a different state, since it did not appear that such out-of-state commerical activities were connected with the intrastate operations affected by the challenged conduct.

Similar reasoning has been used to exempt the concerted activities of intrastate medical groups from the application of the Sherman Act. In *Spears Free Clinic and Hospital for Poor Children v. Cleere*,[129] the plaintiff contended that the defendant medical doctors had conspired to restrain the practice of chiropractic treatment within the state of Colorado. Despite the allegation that persons from other states and nations regularly visited Colorado to obtain such treatment, the court refused to find the necessary impact upon interstate commerce:

> Here, the purpose and object of the conspiracy and of the means adopted to effectuate it, were to restrain the practice of chiropractic and to allocate to the medical profession the practice of the healing arts in Colorado. It is this exclusively local aim and not the fortuitous and incidental effect upon interstate and foreign commerce which gives character to the conspiracy. The effect upon interstate and foreign commerce was fortuitous and remote and not direct and substantial.[130]

The Supreme Court used almost identical reasoning in *United States v. Oregon State Medical Society*,[131] the only case in which it has actually considered the interstate nature of medical practitioner combinations.[132]

127. 313 F. Supp. 435 (W.D. Wash. 1970), *aff'd*, 442 F.2d 1342 (9th Cir.), *cert. denied*, 404 U.S. 881 (1971).

128. 420 F.2d 341 (9th Cir. 1969).

129. 197 F.2d 125 (10th Cir. 1952).

130. *Id.* at 128.

131. 343 U.S. 326 (1952).

132. Although a Sherman Act violation was found in American Medical Ass'n v.

The Court indicated that a medical association conspiracy aimed at restraining the prepaid group medical business in a particular state was not within the jurisdiction of the Sherman Act, since the effect of such an intrastate combination upon interstate commerce was only "sporadic and incidental."[133] Lower federal courts have reached analogous results in Sherman Act cases pertaining to concerted activity undertaken by intrastate medical groups.[134]

The reasoning of the above cases indicates that physician organizations are generally immune from Sherman Act liability if their concerted endeavors are conducted on a relatively localized basis within a single state. An agreement negotiated with an individual hospital, or even with several health care facilities located in a particular county to establish a compensation scale for institutional services such as committee work performed by staff doctors, should be exempt from Sherman Act coverage. A multi-hospital agreement of this type concerning health care facilities in several counties within one state should likewise be outside the jurisdictional purview of the Sherman Act, because the scheme would be fundamentally local in nature, and any impact upon interstate commerce would be remote and incidental.

A more difficult problem concerns the status of a fee-fixing arrangement pertaining to the professional medical services performed by organized physicians within a particular state. While the impact upon individual patients would certainly be confined to the specific state involved, the effect upon insurance carriers might raise complex considerations. Higher medical costs in one state could precipitate increased premium rates in other states if an interstate insurance carrier endeavored to diffuse the extra cost among all of its policy holders. Because such an argument for Sherman Act coverage would, if accepted, effectively obliterate the distinction between interstate and intrastate commerce whenever any interstate enterprise is affected, courts should proceed cautiously.[135] Collectively bargained fee schedules which are

United States, 317 U.S. 519 (1943), this decision did not involve any interstate commerce issue. Since the case arose within the District of Columbia, the federal courts were able to exercise the plenary jurisdiction which section 3 of the Sherman Act provides with respect to restraints of trade occurring within the nation's capital. 15 U.S.C.A. § 3 (1973), *as amended* (Pamphlet No. 1, 1975). *See also* United States v. American Medical Ass'n, 110 F.2d 703 (D.C. Cir.), *cert. denied*, 310 U.S. 644 (1940).

133. United States v. Oregon State Medical Soc'y, 343 U.S. 326, 339 (1952).

134. *See* Elizabeth Hospital, Inc. v. Richardson, 269 F.2d 167 (8th Cir. 1959); Riggall v. Washington County Medical Soc'y, 249 F.2d 266 (8th Cir. 1957); Polhemus v. American Medical Ass'n, 145 F.2d 357 (10th Cir. 1944). *See also* Wolf v. Jane Phillips Episcopal Memorial Medical Center, 513 F.2d 684 (10th Cir. 1975).

135. Although initially one might argue for Sherman Act coverage with respect to

applicable only on an intrastate basis, and other concerted activities intended merely to enhance the economic strength of organized physicians within a particular state, might reasonably be found to be immune from Sherman Act coverage on the basis of the peculiarly local nature of medical practice.[136]

Because of the possibility that a pervasive intrastate medical practitioner combination *might* be found to have the requisite impact upon interstate commerce,[137] and because all multistate group arrangements would automatically affect interstate commerce,[138] it appears that physician organizations might not always be able to avoid Sherman Act liability by relying upon the interstate commerce requirement. In addition, since the Cartwright Act regulates even wholly intrastate restraints upon trade, it becomes imperative to consider recognized antitrust exemptions which might insulate the concerted efforts of doctors from liability under those acts.

Possible Protections Under Recognized Antitrust Exemptions
The "Learned Profession" Exemption

Even if parties have engaged in concerted activity which is other-

concerted activity aimed at affecting the federal Medicare System, it must be remembered that "[t]he test of jurisdiction is not that the acts complained of affect a business engaged in interstate commerce, but that the conduct complained of affects the interstate commerce of such business." Page v. Work, 290 F.2d 323, 330 (9th Cir.), *cert. denied*, 368 U.S. 875 (1961). Despite the fact that Medicare is an interstate program, so long as an intrastate medical group merely affects the operation of that program within a single state, Sherman Act coverage should not be imposed. *But cf.* Goldfarb v. Virginia State Bar, 43 U.S.L.W. 4723, 4727 (June 16, 1975). *Goldfarb* may indicate an opposite result if Medicare and interstate insurance carriers were significantly affected by a wholly intrastate medical price-fixing arrangement.

136. A plaintiff might argue that when concerted conduct substantively constitutes a per se violation of the Sherman Act the requisite jurisdictional standard should be satisfied even if only a de minimis effect upon interstate commerce can be established. Such a contention, however, should not be too readily accepted. While it is recognized that a price-fixing conspiracy which operates on or within the flow of interstate commerce affects such commerce as a matter of law, it is equally established that a similar combination engaged in at an entirely intrastate level does not, as a matter of law, have the required impact upon interstate commerce. Therefore, unless it is demonstrated that the intrastate activities complained of substantially and directly affect interstate commerce, there is no jurisdiction under the Sherman Act despite the otherwise per se nature of the alleged violation. *See* Page v. Work, 290 F.2d 323, 331-32 (9th Cir.), *cert. denied*, 368 U.S. 875 (1961); Las Vegas Merchant Plumbers Ass'n v. United States, 210 F.2d 732, 747 (9th Cir.), *cert. denied*, 348 U.S. 817 (1954).

It should be emphasized that unlike attorneys who frequently have an integral impact upon interstate business despite the seemingly localized nature of a particular transaction being examined, medical practitioners very rarely engage in professional endeavors which are so inextricably intertwined with interstate commerce.

137. *See Physician Unions, supra* note 25, at 997-99.

wise violative of the substantive proscriptions of the Sherman Act and the Cartwright Act, they may nevertheless escape liability under recognized exemptions to the federal and California antitrust laws. These exemptions have been developed to immunize the conduct of certain groups from the coverage of those enactments. The pertinent Sherman Act exemptions will be discussed first; an examination of the Cartwright Act exemptions will follow.

Relevant Sherman Act Exemptions

Two of the traditionally recognized Sherman Act exemptions might be applicable to concerted activities undertaken by a labor-oriented physcian organization. Once concerns the so-called "learned professiones," while the other deals with bona fide labor activities.

The "Learned Profession" Exemption

Although section 1 of the Sherman Act specifically prohibits only restraints upon "trade or commerce,"[139] it has long been recognized that the scope of that provision includes service organizations and their members, even though they deal in services rather than commodities.[140] When the service involved concerned a "learned profession," such as law, medicine, or dentistry, however, it was not wholly clear whether such an activity should be considered to constitute trade within the meaning of the Sherman Act.[141]

In 1931, the Supreme Court specifically recognized that medical practitioners "follow a profession and not a trade"[142] and this concept was confirmed by the Court in 1932 in *Atlantic Cleaners & Dyers, Inc. v. United States.*[143] Although the Court recognized the fact that a

139. See text accompanying note 96 *supra.*

140. *See, e.g.*, United States v. National Ass'n of Real Estate Bds., 339 U.S. 485, 490 (1950); Apex Hosiery Co. v. Leader, 310 U.S. 469, 493 (1940); Atlantic Cleaners & Dyers, Inc. v. United States, 286 U.S. 427, 434-37 (1932). *See generally* Note, *The Applicability of the Sherman Act to Legal Practice and Other "Non-Commercial" Activities*, 82 YALE L.J. 313 (1972).

141. The ambiguous status of the "learned professions" apparently evolved from some wholly gratuitous language contained in an opinion which was construing the term "trade" as utilized in the Coasting and Fishery Act of 1793. "[T]he word 'trade' is often, and indeed generally, used . . . as equivalent to occupation, employment, or business, whether manual or mercantile. Wherever any occupation, employment, or business is carried on for the purpose of profit, or gain, or a livelihood, *not* in the liberal arts or *in the learned professions*, it is constantly called a trade." The Nymph, 18 F. Cas. 506, 507 (No. 10, 388) (C.C. Me. 1834) (emphasis added).

142. FTC v. Raladam Co., 283 U.S. 643, 653 (1931).

143. 286 U.S. 427 (1932).

business consisting primarily of personal services should be considered a trade within the meaning of the federal antitrust laws, it specifically indicated that services involving one of the "learned professions" *might* not be so regarded.[144] Some lower courts thus continued to hold that the "learned professions" were not trades within the meaning of the Sherman Act.[145]

In its recent decision in *Goldfarb v. Virginia State Bar*, the Supreme Court held that the "learned professions" are not ipso facto exempt from Sherman Act coverage merely because of the professional nature of the services provided.[146] The Court rejected the effort of a state bar association to achieve complete antitrust immunity through the "learned profession" exemption, since it could not "find support for the proposition that Congress intended any such sweeping exclusion" from the pervasive jurisdictional scope of the Sherman Act.[147] It thus concluded that "[t]he nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act, nor is the public service aspect of professional practice controlling in determing whether § 1 includes professions."[148] The Court in *Goldfarb* indicated, however, that some

144. *Id.* at 436; *see* United States v. National Ass'n of Real Estate Bds., 339 U.S. 485 (1950).

145. *See, e.g.*, Riggall v. Washington County Medical Soc'y, 249 F.2d 266, 268 (8th Cir. 1957), *cert. denied*, 355 U.S. 954 (1958); United States v. Oregon State Medical Soc'y, 95 F. Supp. 103 (D. Ore. 1950), *aff'd on other grounds*, 343 U.S. 326 (1952). *But see* United States v. American Medical Ass'n, 110 F.2d 703, 710 (D.C. Cir.), *cert. denied*, 310 U.S. 644 (1940).

146. Goldfarb v. Virginia State Bar, 43 U.S.L.W. 4723 (U.S. June 16, 1975).

147. *Id.* at 4728.

148. *Id.* (citations omitted). The Court further indicated that it was no disparagement of a profession to acknowledge that its involvement with "the exchange of [a professional] service for money is 'commerce' in the most common usage of that word," thus subjecting the business aspects of the profession to Sherman Act regulations. *Id.*

It is interesting to note that even in the absence of the *Goldfarb* decision, there would have been a substantial likelihood that pernicious activities undertaken by a physician-union would nonetheless have been subject to Sherman Act coverage. In American Medical Ass'n v. United States, 317 U.S. 519 (1943), the Supreme Court was able to apply the federal antitrust laws to the activities of a medical association by using an innovative analysis which obviated the necessity of deciding whether any "learned profession" immunity should be officially recognized. In that case, the medical association and its physician-members were charged with conspiring to restrain and obstruct the prepaid medical program of Group Health. The Court first determined that the Group Health enterprise was engaged in a business or trade within the meaning of the Sherman Act. It then noted that the Sherman Act prohibits "every *person*" from combining to impose a proscribed restraint upon "trade or commerce," and concluded that the legal status of the occupation practiced by the defendant physicians was immaterial, since the purpose and effect of their conspiracy was the restraint of the Group Health business. *Id.* at 528. (Although the case arose under section 3 of the Sherman Act, 15 U.S.C. section 3, since it pertained to a combination within the District of Columbia, it is important to

limited antitrust immunity not provided for ordinary commercial activities might still be available to the organized endeavors of lawyers and medical practitioners because of their professional status:

> The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions as interchangeable with other business activities, and automatically to apply to the professions antitrust concepts which originated in other areas. The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently.[149]

Therefore, if a physician organization engaged in conduct clearly intended to enhance the ethical or professional standards of the medical profession, its endeavors would quite possibly be immune from Sherman Act coverage. If a physician union undertook concerted activities for the primary purpose of benefiting the personal economic interests of its practitioner-members,[150] however, any protection which might otherwise

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note that the operative language of that section is identical to the relevant portion of section 1 of the Sherman Act. Therefore, under the rationale of the *American Medical Association* holding, any anticompetitive concerted activity taken against a health care institution or an insurance carrier, both of which clearly constitute "trade" within the meaning of the Sherman Act (*see, e.g.*, United States v. South-Eastern Underwriters (1943)), for the purpose of enhancing the commercial interest of medical practitioners, would have transcended the scope of any blanket protection which might otherwise have been provided by a "learned profession" exemption which existed prior to the *Goldfarb* decision).

149. 43 U.S.L.W. at 4728 n.17. This statement was basically a reiteration of the position which the Supreme Court had previously enunciated in United States v. Oregon State Medical Soc'y, 343 U.S. 326, 336 (1952), in which it had observed: "[T]here are ethical considerations where the historic direct relationship between patient and physician is involved which are quite different than the usual considerations prevailing in ordinary commercial matters. This Court has recognized that forms of competition usual in the business world may be demoralizing to the ethical standards of a profession." *See also* Semler v. Oregon State Bd. of Dental Examiners, 294 U.S. 608 (1935).

150. Because of the business-oriented nature of labor organizations, no bona fide physicians' union would be able to rely upon the "traditionally non-commercial" exception to Sherman Act coverage recognized in Marjorie Webster Junior College v. Middle States Ass'n of College & Secondary Schools, 432 F.2d 650 (D.C. Cir.), *cert. denied*, 400 U.S. 965 (1970): "[T]he proscriptions of the Sherman Act were 'tailored . . . for the business world,' not for the *non-commercial aspects* of the liberal arts and the learned professions. In these contexts, an incidental restraint of trade, *absent an intent or purpose to affect the commercial aspects of the profession*, is not sufficient to warrant application of the antitrust laws." *Id.* at 654 (emphasis added) (citations omitted). Any concerted effort by a physician organization designed to enhance the doctors' economic position would directly pertain to the "commercial" aspects of the medical profession and it would ipso facto exceed the scope of protection afforded by the rationale enunciated in

be available to professionals under the rationale enunciated in the *Goldfarb* and *Oregon State Medical Society* decisions would most likely be forfeited.[151] The organization would thus have to rely upon some other antitrust exemption.

The Labor Exemption

Sections 6 and 20 of the Clayton Act[152] have been interpreted in concert with sections 4 and 13 of the Norris-La Guardia Act[153] to provide labor organizations with a partial exemption from the federal antitrust laws. The statutorily created labor exemption immunizes union activities from Sherman Act liability to the extent they are conducted in furtherance of union objectives and occur within the perimeters of a "labor dispute," as that term is defined in section 20 of the Clayton Act as read in conjunction with section 13 of the Norris-La Guardia Act:[154]

Marjorie Webster. See generally Coons, *Non-Commercial Purpose as a Sherman Act Defense*, 56 NW. U.L. REV. 705 (1962).

151. Although a physicians' union might argue that the establishment of minimum fee schedules would effectively guarantee competent and conscientious medical care, it is doubtful that a court would allow such reasoning to immunize the otherwise per se violation of the Sherman Act which would be involved. *See Physician Union*, *supra* note 26, at 994-95; Note, *The Applicability of the Sherman Act to Legal Practice and Other "Non-Commercial Activities*, 82 YALE L.J. 313, 333-34 (1972).

152. Section 6, 15 U.S.C. section 17 (1970), provides in relevant part: "The labor of a human being is not a commodity or article of commerce. Nothing contained in the antitrust laws shall be construed to forbid the existence and operation of labor . . . organizations, instituted for the purposes of mutual help . . . or to forbid or restrain any individual members of such organizations from lawfully carrying out the legitimate objects thereof; nor shall such organizations, or the members thereof, be held or construed to be illegal combinations or conspiracies in restraint of trade, under the antitrust laws."

Section 20, 29 U.S.C. section 52 (1970), provides in relevant part: "No restraining order or injunction shall be granted by any court of the United States . . . in any case between an employer and employees, or between employers and employees, or between employees, or between persons employed and persons seeking employment, involving, or growing out of, a dispute concerning terms or conditions of employment . . . ."

153. 29 U.S.C. § 104, 113 (1970). Section 113 provides in relevant part: "(b) A person or association shall be held to be a person participating or interested in a labor dispute . . . if he or it is engaged in the same industry, trade, craft, or occupation in which the dispute occurs, or has a direct or indirect interest therein, or is a member . . . of any association composed in whole or in part of employers or employees engaged in such industry, trade, craft, or occupation. (c) The term 'labor dispute' includes any controversy concerning terms or conditions of employment, or concerning the association or representation of persons in negotiating, fixing, maintaining, changing, or seeking to arrange terms or conditions of employment, regardless of whether or not the disputants stand in the proximate relation of employer and employee."

154. *See, e.g.*, Meat Cutters Local 189 v. Jewel Tea Co., 381 U.S. 676 (1965); United Mine Workers v. Pennington, 381 U.S. 657 (1965); Hunt v. Crumboch, 325 U.S. 821 (1945); United States v. Hutcheson, 312 U.S. 219 (1941). *See generally* Cox,

> So long as a union acts in its self-interest and *does not combine with non-labor groups*, the licit and illicit under section 20 [of the Clayton Act] are not to be distinguished by any judgment regarding the wisdom or unwisdom, the rightness or wrongness, the selfishness or unselfishness of the end of which the particular union activities are the means.[155]

As the italicized language indicates, however, the scope of the labor exemption is not limitless.

When a labor organization combines with non-labor groups to effectuate an inappropriate restraint upon interstate commerce, the union is unable to rely upon the protection provided by the labor exemption: "Congress never intended that unions could, consistently with the Sherman Act, aid non-labor groups to create business monopolies and to control the marketing of goods and services."[156]

To be able effectively to invoke the labor exemption from the federal antitrust laws, a labor organization and its members must initially be able to demonstrate that one of two situations is present: (1) the disputing parties stand in the relationship of employer and employee and the dispute affects some aspect of that relationship; or (2) the employer-employee relationship of other parties constitutes the crux of the dispute precipitating the antitrust case.[157] Therefore, when truly independent businessmen combine, even in the guise of a labor organization, they cannot resort to the labor exemption to immunize conduct which restrains trade, since their conduct is realistically intended to enhance their own entrepreneurial interests, rather than meaningfully to affect some employer-employee relationship.[158] The exemption is unavailable even if such independent businessmen pursue their economic objectives in conjunction with an organization which also represents bona fide employees.[159] It follows that if medical practitioners who are

Labor and the Antitrust Laws—A Preliminary Analysis, 104 U. PA. L. REV. 252 (1955); Meltzer, *Labor Unions, Collective Bargaining, and the Antitrust Laws*, 32 U. CHI. L. REV. 659 (1965); Smith, *Antitrust and Labor*, 53 MICH. L. REV. 1119 (1955); Winter, *Collective Bargaining and Competition: The Application of Antitrust Standards to Union Activities*, 73 YALE L.J. 14 (1963); Comment, *Labor's Antitrust Exemption*, 55 CALIF. L. REV. 254 (1967).

155. United States v. Hutcheson, 312 U.S. 219, 232 (1941) (emphasis added) (citation omitted); *see* Hunt v. Crumboch, 325 U.S. 821, 825 (1945).

156. Allen Bradley Co. v. IBEW Local 3, 325 U.S. 797, 808 (1945); *see* United Mine Workers v. Pennington, 381 U.S. 657, 664-66 (1965).

157. *See* American Medical Ass'n v. United States, 317 U.S. 519, 534-36 (1943); Columbia River Packers Ass'n v. Hinton, 315 U.S. 143 (1942); New Negro Alliance v. Sanitary Grocery Co., 303 U.S. 552 (1938).

158. *See, e.g.*, United States v. National Ass'n of Real Estate Bds., 339 U.S. 485,

157. *See* American Medical Ass'n v. United States, 317 U.S. 519, 534-36 (1943);

159. *See, e.g.*, Los Angeles Meat & Provision Drivers Union v. United States, 371

truly independent entrepreneurs were to unite for the purpose of benefiting their personal business interests through price-fixing or other concerted activities, they would be unable to avail themselves of the protection provided by the labor exemption. On the other hand, it should also be clear that legitimate concerted activities undertaken by a physician organization which actually represents employee-doctors who have a bona fide employment relationship with a health care institution or some other employer would be substantially immunized from Sherman Act liability under the rationale of the labor exemption.

In light of the pervasive strands of control which are becoming more frequently a characteristic of the relationship between a health care facility and its staff physicians,[160] it would certainly not be unrealistic to regard the connection as an employment relationship rather than as an independent contractor relationship.[161] If this course were followed, the labor exemption might reasonably be applicable to concerted action undertaken by such doctors in an effort legitimately to enhance the terms or conditions of employment inherent in that relationship. On the other hand, coordinated activities motivated by a desire to advance *personal* business interests not meaningfully related to the employment relationship existing between such staff physicians and the employing institution would not fall within the purview of the labor exemption, because the requisite connection to a labor dispute would be lacking.[162]

It was noted earlier that for labor relations purposes, medical practioners are realistically viewed as independent contractors, rather than as employees, in their customary relationship with insurance carriers, which merely reimburse the doctors for services they provide to insured patients.[163] This conclusion might initially appear to preclude

U.S. 94 (1962); Taylor v. Horseshoers Local 7, 353 F.2d 593 (4th Cir. 1965), *cert. denied*, 384 U.S. 969 (1966); United States v. Olympia Provision & Baking Co., 282 F. Supp. 819 (S.D.N.Y. 1968), *aff'd per curiam*, 393 U.S. 480 (1969).

160. See notes 67-78 & accompanying text *supra*. See text accompanying notes 2-28 *supra*.

161. See notes 47-78 & accompanying text *supra*.

162. See text accompanying notes 157-58 *supra*. "[B]y the terms of the statute [Norris-La Guardia Act] there may be a 'labor dispute' where the disputants do not stand in the proximate relation of employer and employee. *But the statutory classification, however broad, of parties and circumstances to which a 'labor dispute' may relate does not expand the application of the Act to include controversies upon which the employer-employee relationship has no bearing.*" Columbia River Packers Ass'n v. Hinton, 315 U.S. 143, 146-47 (1942) (emphasis added) (citation omitted). *See* Connell Construction Co. v. Plumbers and Steamfitters Local 100, 43 U.S.L.W. 4657 (June 2, 1975).

163. See note 49 *supra*.

application of the labor exemption to all concerted activities used by organized doctors to affect the economic interests of physicians vis-à-vis such insurance companies. Nevertheless, such a presumption should not be too readily accepted.

In *Local 24, International Brotherhood of Teamsters v. Oliver*,[164] the Supreme Court recognized the appropriateness of a collective bargaining agreement negotiated by the Teamsters Union which specifically defined the rental schedules applicable to owner-drivers of trucking equipment,[165] despite the fact that such owner-drivers were independent businessmen who did not constitute employees within the meaning of the NLRA. Since the Teamsters Union represented employee-drivers who were employed to operate trucking equipment owned by their employers, the Court determined that the objective of the union in negotiating the rental fee schedule which applied to the independent owner-drivers was to protect the collectively bargained wage scale of the employee-drivers against possible undermining through a diminution of rental fees charged by owner-drivers. The Court concluded that the negotiated provisions did not embody a "remote and indirect approach to the subject of wages," but rather constituted "a direct frontal attack upon a problem thought to threaten the maintenance of the basic wage structure established by the collective bargaining contract."[166]

The rationale of the *Oliver* decision[167] was reiterated by the Supreme Court in *American Federation of Musicians v. Carroll*,[168] wherein the Court rejected a federal antitrust challenge to the musicians union practice of establishing and enforcing minimum price schedules which were applied to contractual arrangements undertaken by independent orchestra leaders.[169] Although the independent orchestra leaders were considered to be businessmen rather than employees, the Court determined that they constituted a labor group and were parties

164. 358 U.S. 283 (1959).

165. "Owner-drivers" are individuals who own trucking equipment which they lease to companies on a fee basis. The fee covers the rental of the equipment, labor services provided by the owner-driver, and a profit margin for the owner-driver. *See id.* at 286-87.

166. 358 U.S. at 294.

167. Although the *Oliver* decision directly concerned the question of whether a state could, consistent with the federal preemption doctrine, apply its antitrust law to the activities in issue, the reasoning of the Supreme Court clearly would have precluded Sherman Act liability in that case owing to the applicability of the labor exemption.

168. 391 U.S. 99 (1968).

169. The musicians' union effectuated its price scheme by requiring the orchestra leaders to become union members as a prerequisite to their working with musicians' union sidemen. The requirement subjected the leaders to internal union discipline if they failed to comply with the prescribed price regulations. *See id.* at 102-05.

to a labor dispute, owing to the presence of direct job and wage competition between them and the employee-members of the musicians union. The Court concluded that the labor exempton was applicable. While the opinion recognized that the union regulations technically affected "prices," rather than "wages," the Court cautioned against exalting form over substance, emphasizing that "the crucial determinant is not the form of the agreement—*e.g.*, prices or wages—but its relative impact on the product market and the interests of the [employed] union members."[170] The Court further indicated that the critical inquiry in cases such as *Carroll* and *Oliver* is whether the price schedules or other restrictions imposed upon the independent contractors in actuality operate to protect the wages or other substantial and legitimate interests of the employee-members of the union involved.[171]

In the immediate future, there will be increasing pressure for the establishment and proliferation of institutions such as health maintenance organizations[172] which will involve the actual employment of many staff physicians. The ability of such enterprises to operate successfully will be essentially dependent upon their capacity to provide medical protection which the general public perceives as being financially preferable to the utilization of doctors and hospitals on an ad hoc basis. Therefore, if a physician union were to endeavor effectively to enhance the compensation levels and working conditions of the staff doctors employed by such group health entities, it might well be affected by direct competition from independent contractor doctors who accept each case on a fee-for-service basis.[173] It would then be reasonable to argue that efforts by a physician union to regulate the fee schedules of independent contractor practitioners should be protected by the labor exemption in appropriate cases as "a direct frontal attack upon a problem thought to threaten the maintenance of the basic wage structure" negotiated for doctors employed by group health enterprises, even though such an arrangement would likely increase the financial

170. 391 U.S. at 107; *see* Meat Cutters Local 189 v. Jewel Tea Co., 381 U.S. 676, 690 n.5 (1965).

171. 391 U.S. at 108.

172. See notes 14-20 & accompanying text *supra.*

173. Two forms of competition would exist between independent contractor physicians and doctors employed by group health enterprises: (1) direct wage competition similar to that present in *Oliver* and *Carroll* which could significantly affect the compensation levels that the union could reasonably demand for its employee-members and (2) job competition based on the ability of independent contractor-doctors to reduce their fee schedules as a means of encouraging patients of group health programs to reject those plans and return to traditional practitioners.

burden of health insurance carriers which reimburse such independent doctors for their services.[174]

Since the establishment of any artificial fee schedules for independent practitioners would certainly have some detrimental impact upon the general public, the scope of the *Oliver-Carroll* exemption as applied to organized employee-physicians should be reasonably narrow. The physician organization endeavoring to use the protection afforded by the labor exemption should be required to demonstrate that the independent practitioners whose fee schedules are being affected are truly competing with the employee-physicians in such a direct manner that a diminishment of their fee schedules would be likely to threaten the compensation levels or job security of the employee-doctors involved.[175] Without such proof, price-fixing attempts should not be accorded labor exemption protection, since they would actually involve only a "remote and indirect approach to the subject of wages."[176] Although this approach would impose a tangible burden upon a physician organization which desired to avail itself of the antitrust immunity provided by the labor exemption, it would at least permit such a union to enjoy some protection when it truly acted to enhance the direct and legitimate interests of its employee-members, and it would simultaneously prevent unnecessarily pervasive price-fixing schemes which would be injurious to the public interest.[177]

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174. See text accompanying note 166 *supra*. The labor exemption would not immunize concerted fee-fixing arrangements involving staff doctors who are not yet being compensated by the institution which exercises sufficient control over the physicians to create a limited employment relationship (see notes 76-79 *supra*), but who are instead remunerated through their own direct billing of patients, since such fee-fixing activities would not be sufficiently related to the employment relationship in question to warrant protection.

175. This conclusion presumes, of course, that the organized employee-physicians are using legitimate means to accomplish their objective. The use of internal union regulations which would preclude union members from dealing with independent practitioners who are in direct competition with employed physicians and who do not observe the union-established fee schedules should be regarded as appropriate primary conduct similar to that utilized in *Carroll*. Furthermore, it would not be unreasonable to allow a physician union to negotiate directly either with those independent practitioners who threaten the compensation levels or job security of employee-doctors or with the insurance entities which remunerate such practitioners for their services, in an effort to obtain a satisfactory fee-schedule agreement. Resort to bona fide "strike" activities against such parties during negotiations might similarly be accorded labor exemption protection.

176. See text accompanying note 166 *supra*.

177. This suggested approach would constitute an extension of the *Oliver-Carroll* rationale, since it would permit a physician organization to affect parties who do not ordinarily have direct dealings with employee-members of the union. In *Oliver*, the challenged arrangement had been directly negotiated with the company which employed

Relevant Cartwright Act Exemptions

Activities of a physician organization which unreasonably restrain trade within California are subject to the substantive coverage of the Cartwright act.[178] Unless the doctors involved in such concerted conduct can avail themselves of the protection afforded by one of the recognized exemptions from the California antitrust statute,[179] they can be subjected to substantial liability.

"Professions" Exemption

In *Willis v. Santa Ana Community Hospital Association*,[180] the California Supreme Court held that the provisions of the Cartwright Act are inapplicable to restraints involving the medical profession. The court noted that the language describing the types of combinations made unlawful by the Cartwright Act does not include the term "profession."[181] The court thought it significant that section 16600 of the Business and Professions Code, rendering void those contracts which restrain persons from engaging in "a lawful profession, trade or business of any kind," specifically included the term "profession," notwithstanding the use of the words "trade" and business," even though the provision was enacted at the same time as the Cartwright Act.[182] The Court thus

the union drivers threatened by the activities of the independent owner-drivers, and in *Carroll*, the orchestra leaders who were affected by the union scheme directly employed union sidemen. Such direct connecting strands would usually not be present between independent practitioners and a bona fide physicians' union.

178. See text accompanying notes 96-118 *supra*.

179. It should be noted that were a bona fide physician union to engage in activity which might constitute a substantive violation of the Cartwright Act, but which is also regulated by the provisions of the NLRA, the federal preemption doctrine would preclude application of the California antitrust law. *See* Connell Construction Co. v. Plumbers and Steamfitters Local Union No. 100, 43 U.S.L.W. 4657, 4663 (June 2, 1975); Teamsters Local 24 v. Oliver, 358 U.S. 283 (1959); Weber v. Anheuser-Busch, Inc., 348 U.S. 468 (1955). Under such circumstances, only reliance upon the federal antitrust statutes would be possible. With respect to those endeavors not within the jurisdictional purview of the NLRA, however, the exercise of state antitrust authority would not be inappropriate. *See* 43 U.S.L.W. at 4663.

180. 58 Cal. 2d 806, 376 P.2d 568, 26 Cal. Rptr. 640 (1962).

181. *Id.* at 809, 376 P.2d at 569, 26 Cal. Rptr. at 641. The court indicated that while there had been cases giving the statutory language a rather broad interpretation to include restraints involving such services as barbering (Messner v. Barbers Union, 53 Cal. 2d 873, 886, 351 P.2d 347, 355, 4 Cal. Rptr. 179, 187 (1960)) and maintenance work (People v. Building Maintenance Contractors Ass'n, 41 Cal. 2d 719, 723, 264 P.2d 31, 34 (1953)), there had been no California decisions bringing the professions within the coverage of the Cartwright Act, 58 Cal. 2d at 809, 376 P.2d at 570, 26 Cal. Rptr. at 642.

182. 58 Cal. 2d at 809, 376 P.2d at 570, 26 Cal. Rptr. at 642.

decided that the difference in terminology between section 16600 and the Cartwright Act could reasonably be viewed as indicating that the latter enactment was not intended to apply to the professions, and it noted that "antitrust legislation providing for treble damages should not be applied to the professions unless the language clearly calls for such an application."[183] It therefore concluded that the language of the Cartwright Act did not mandate such applicability to restraints involving the medical profession.[184]

Although the *Willis* decision appears to indicate that a physician organization would not be subject to Cartwright Act laibility for any restrictions it might impose upon the medical profession itself, it does not necessarily mean that concerted conduct by physicians which significantly affects insurance carriers would be so insulated. A restraint imposed upon the business of insurance may fall within the purview of the Cartwright Act.[185] Since the type of trust prohibited by the Cartwright Act includes activity involving "two or more *persons*,"[186] a California court might reasonably analogize a restraint by the medical profession which affected the insurance business to the situation considered by the United States Supreme Court in *American Medical Association v. United States*,[187] in which the practice of group health services was the target of the medical practitioner's restraint. A California court could thus find an illegal restraint by physicians in violation of the Cartwright Act, based upon the premise that the status of the defendants is irrelevant, so long as their combined activities directly affect some non-medical business[188] which constitutes trade or commerce within the

183. *Id.*

184. *Id.; see* Osteopathic Physicians & Surgeons v. California Medical Ass'n, 224 Cal. App. 2d 378, 36 Cal. Rptr. 641 (1964), in which the court similarly determined that the Cartwright Act did not apply to restraints involving the practice of medicine.

185. *See* Speegle v. Board of Fire Underwriters, 29 Cal. 2d 34, 172 P.2d 867 (1946).

186. CAL. BUS. & PROF. CODE § 16720 (West 1964) (emphasis added).

187. 317 U.S. 519 (1943). See note 148 *supra.*

188. In Tatkin v. Superior Ct., 160 Cal. App. 2d 745, 757-65, 326 P.2d 201, 208-13 (1958), the appellate court indicated the belief that physicians who conspire to restrain the practice of medicine could be held liable under common law restraint of trade principles, regardless of whether the Cartwright Act would apply to such circumstances. Nevertheless, since the Cartwright Act was legislatively intended to codify the common law rules pertaining to restraints upon trade (see note 98 *supra*), it would be entirely incongruous for a court to recognize that a restraint upon the medical profession is not cognizable under the Cartwright Act, while simultaneously imposing liability for such conduct under purported common law principles. Such judicial action would constitute an unwarranted circumvention of the legislative intent evidenced by the exclusion of the professions from the coverage of CAL. BUS. & PROF. CODE section 16720. See notes 182-

meaning of section 16720(a). Under such circumstances, the defendants would be forced to seek protection in another exemption.

The Labor Exemption

Section 16703 of the California Business and Professions Code specifically provides that "labor, whether skilled or unskilled, is not a commodity" within the meaning of the Cartwright Act. This provision has been interpreted as providing bona fide labor organizations with an immunity from California antitrust legislation analogous to that available under the federal labor exemption.[189]

Although the California labor exemption does not protect a labor union from Cartwright Act liability if it combines with nonlabor groups to effectuate an improper restraint of trade,[190] the California Supreme Court has held that a union may legitimately impose unilateral restraints which affect independent businessmen when such restrictions are reasonably necessary to protect the wages and working conditions of employee-members of that union from the deleterious effects caused by direct competition between the independent entrepreneurs and the employee-members.[191] Thus, the principles previously discussed with respect to the *Oliver-Carroll* corollary to the federal labor exemption[192] should be applicable to the California labor exemption through a reasonable extrapolation of the theories enunciated by the California Supreme Court. For this reason, a physician organization should be permitted to endeavor by legal means[193] to impose restraints upon

84 & accompanying text *supra*. Furthermore, since the definitive decisions in *Willis* and *Osteopathic Physicians & Surgeons* were rendered subsequent to the *Tatkin* decision, it is most probable that the belief which was only parenthetically and gratuitously discussed in *Tatkin* would not be applied in the future.

189. *See, e.g.*, Schweizer v. Local Joint Executive Board, 121 Cal. App. 2d 45, 262 P.2d 568 (1953); Riviello v. Barbers Union, 88 Cal. App. 2d 499, 199 P.2d 400 (1948).

190. *See, e.g.*, Overland Publishing Co. v. H.S. Crocker Co., 193 Cal. 109, 117-18, 222 P. 812, 815-16 (1924).

191. *See, e.g.*, Messner v. Barbers Union, 53 Cal. 2d 873, 885-87, 351 P.2d 347, 354-56, 4 Cal. Rptr. 179, 186-88 (1960); Bautista v. Jones, 25 Cal. 2d 746, 749-51, 155 P.2d 343, 345-46 (1944).

192. See notes 164-77 & accompanying text *supra*.

193. See note 175 *supra*. Courts have suggested that California common law principles relating to unlawful interference with a business, trade, or occupation may impose liability upon medical associations and their physician-members, even when their interference affects only the practice of medicine, if improper or unjustified business techniques are used. *See* Willis v. Santa Ana Community Hosp. Ass'n, 58 Cal. 2d 806, 810, 376 P.2d 568, 570, 26 Cal. Rptr. 640, 642 (1962); Osteopathic Physicians & Surgeons v. California Medical Ass'n, 224 Cal. App. 2d 378, 396, 36 Cal. Rptr. 641, 652 (1964). In Parkinson Co. v. Building Trades Council, 154 Cal. 581, 98 P. 1027 (1908),

independent practitioners who are demonstrably competing with the employee-doctors represented by that organization in such a reasonably direct manner that their fee schedules are likely to threaten the compensation levels or job security of the employee-physicians involved.[194]

Conclusion

In recent years, the health care industry has undergone significant changes, and this process will undoubtedly continue in the future. The once wholly independent physicians are being subjected to increasing control exercised by the medical facilities where they perform their professional services and the large insurance carriers which remunerate them for the vast majority of their work. The strong impetus, both legislative and social, for the establishment of complete health care centers which can supply total medical services on a set fee, prepayment basis, will eventually result in the actual employment of many doctors on a regular salaried basis.

Individual physicians are incapable of effectively dealing with the well organized insurance and health care entities which increasingly affect their professional lives. As a result, many practitioners are organizing labor unions and associations which they hope can represent their interests. If anachronistic legal doctrines are perfunctorily applied to such organizations, however, the doctors will be unfairly disenfranchised. It is time for courts to recognize the fact that contemporary realities necessitate the reconsideration of traditional theories and, in some cases, the development of somewhat novel concepts.

When health care institutions exercise significant control over the professional work performed by their staff physicians, it should be recognized that employment, rather than independent contractor, relationships are involved. This view would permit physician organizations to represent employee-doctors under the protections afforded by applicable labor relations legislation. To the extent such organizations engage in legitimate concerted activities intended to protect their employee-

however, the California Supreme Court indicated that when organized labor engages in legitimate activities pertaining to the protection of some bona fide employment relationship, they are not liable under common law interference theories. To the extent that the modest proposals contained in this article are accepted regarding the applicability of the California and federal labor exemptions to reasonable conduct undertaken by physician unions to protect their employee-members from the adverse effects which might be caused by direct competition with independent practitioners, those organizations and their physician-members should similarly be considered immune from liability under common law business interference doctrines.

194. See notes 172-77 & accompanying text *supra*.

members from the deleterious effects of direct competition with independent practitioners, such conduct, even when it effectively regulates the fee schedules or other aspects of the individual practitioners' work, should be exempt from California or federal antitrust liability through application of the labor exemption. Such a result would do no more than provide employee-physicians with rights commensurate with those already enjoyed by other workers. Anything less would constitute invidious discrimination based solely upon the currently exalted economic status of physicians.